MEDICARE ANNUAL REPORT TO CONGRESS

Fiscal Year 1989

Including the Report on the
Medicare Validation Surveys of Hospitals
Accredited by
The Joint Commission of Accreditation
of Healthcare Organizations

And
The Medicare Supplement Voluntary
Certifications Program Report

U.S. Department of Health and Human Services
Health Care Financing Administration

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— Contents —

Abbreviations and Acronyms ii

Executive Summary 1

Chapter I: The Medicare Population and Benefits 7

Chapter II: Ensuring Quality of Care 13

Chapter III: Encouraging Competition and Choice 17

Chapter IV: Efficient Operation of Medicare 21

Chapter V: Research, Demonstrations and Evaluations 33

Chapter VI: Promoting Improvements in HCFA 49

Chapter VII: Significant Regulations Published In FY 1989 53

Chapter VIII: Reports and Publications 55

Chapter IX: Medigap Voluntary Certification Program Report 59

Chapter X: Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission of Accreditation of Healthcare Organizations 63

Abbreviations and Acronyms

AAPCC ..... Adjusted average per capita cost
ADLS ..... Activities of daily living
AFDC ..... Aid to Families with Dependent Children
AHCCCS ..... Arizona Health Care Cost Containment System
AID ..... Acquired immune deficiency
AIDS ..... Acquired immune deficiency syndrome
ATB ..... All trunks busy
BITS ..... Beneficiary Inquiry Tracking System
BMAD ..... Part B Medicare annual data
BPD ..... Bureau of Policy Development
CAP ..... College of American Pathologists
CASR ..... Contractor Auditing and Settlement Report
CMP ..... Competitive medical plan
COBRA ..... Consolidated Omnibus Budget Reconciliation Act
COP ..... Conditions of participation
CPEP ..... Contractor performance evaluation program
CPT ..... Claims processing timeliness
CRNA ..... Certified Registered Nurse Anesthetists
CSI ..... Computerized severity index
CWF ..... Common working file
DCG ..... Diagnostic cost group
DME ..... Durable medical equipment
DOJ ..... Department of Justice
DRG ..... Diagnosis related group
EAP ..... Employee Assistance Program
EKGs ..... Electrocardiographic
EEO ..... Equal Opportunity Employment
EMC ..... Electronic media claim
ESRD ..... End-stage renal disease
EUC ..... End-user computing
FICA ..... Federal Insurance Contributions Act
FIs ..... Fiscal intermediaries
FY ..... Fiscal year
GHP ..... Group health plan
HCFA ..... Health Care Financing Administration
HCPCS ..... HCFA Common Procedure Coding System
HCPPs ..... Health care prepayment plans
HHA ..... Home health agency
HHS ..... U.S. Department of Health and Human Services
HMO ..... Health maintenance organization
ICF ..... Intermediate care facility
JCAHO ..... Joint Commission on Accreditation of Healthcare Organizations
LGHPs ..... Large groups health plans
LSC ..... Life Safety Code
MCCA ..... Medicare Catastrophic Coverage Act
MIGs ..... Medicare insured groups
MSP ..... Medicare Secondary Payer Program
NAIC ..... National Association of Insurance Commissioners
NDG ..... National Design Group
NDM ..... Network Data Mover
NDRR ..... National Data Reporting Requirements
NTIS ..... National Technical Information Services
OBRA ..... Omnibus Budget Reconciliation Act
ORD ..... Office of Research and Demonstrations
PICS ..... Plan Information Control System
P.L. ..... Public law
PMTT ..... Programmable Magnetic Tape Terminal
POS ..... Point of sale
PPS ..... Prospective payment system
PRISM ..... Project to Redesign Information System Management
PRO ..... Peer Review Organization
QA ..... Quality assurance
R&D ..... Research and demonstrations
RHHI ..... Regional home health intermediaries
SA ..... State agencies
SBIR ..... Small Business Innovative Research
SNF ..... Skilled nursing facility
TEFRA ..... Tax Equity and Fiscal Responsibility Act
UPIN ..... Unique Physician Identification Numbers
VAN ..... Value Added network

Executive Summary

Beneficiaries

During FY 1989 the number of Medicare beneficiaries increased by approximately 590,000 from 33 million to 33.6 million (Table 1). About 2.07 million of the newly enrolled beneficiaries were 65 years of age and older, bringing to 30.4 million the number of elderly enrolled in Medicare: 360,000 were younger disabled persons, boosting the number of disabled beneficiaries to 3.2 million. Of the total number of beneficiaries, 32.9 million were residents of the United States, 430,000 lived in U.S. commonwealths and territories, and 264,000 resided in other countries.

Nearly 95 percent (28.6 million) of the aged and 98 percent (2.8 million) of the disabled were enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medicare Insurance (Part B). Approximately 95 percent of the Medicare enrollees residing in the 50 States and the District of Columbia were covered by both parts (Table 2).

Health Care Providers

At the close of the fiscal year, 5,582 short-stay and 290 long-stay hospitals with about 1.1 million beds were participating in Medicare, as were 8,198 skilled nursing facilities (SNFs), 170 comprehensive outpatient rehabilitation facilities, 5,546 home health agencies (HHAs), and 4,613 independent laboratories. Other participating health care providers included 1,096 ambulatory surgical centers, 703 hospices, 484 rural health clinics and 1,875 end-stage renal disease (ESRD) facilities or units providing services to Medicare beneficiaries requiring maintenance dialysis or kidney transplants.

Participating Physicians and Suppliers

About 40.7 percent of physicians (283,475) and 21.0 percent of the medical suppliers (24,938) serving Medicare beneficiaries signed participation agreements with HCFA for the 1989 calendar year. Physicians and suppliers may make a voluntary choice each year to participate in Medicare and to accept assignment on all Medicare claims. Participating physicians and suppliers agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. Beneficiaries are billed only for applicable deductible and coinsurance amounts.

Benefit Payments

Medicare benefit payments totaled about $94.2 billion in FY 1989 or 10.1 percent more than the benefit outlay for the previous fiscal year (Table 3). Benefits paid under the hospital insurance program (Part A) amounted to $57.3 billion, while those paid under the supplementary medical insurance (SMI) program (Part B) totaled $36.9 billion. Inpatient hospital care accounted for $52.4 billion, or 91.4 percent, or Part A spending while 4.4 percent went for home health care, and about 3.8 percent for SNF care. The balance was spent on hospice care. Physician services and independent laboratory costs accounted for 74 percent, outpatient services for 19.9 percent, and home health care and prepayment plans for 6.1 percent of Part B spending. The $26.1 billion spent for physician services was almost $1.9 billion more than the FY 1988 outlay and represented nearly 70.9 percent of Part B spending for the year.

Program Funding

Ninety percent of the financing for Medicare Part A is derived from employment taxes paid by workers and their employers, and by self-employed individuals. The remainder comes from Federal general revenues and other sources. Part B is financed by three sources: (1) premium payments from enrollees (25 percent); (2) contributions from general revenues (73 percent); and (3) interest on balances in the SMI Trust Fund (2 percent). Enrollees paid a monthly Part B premium of $27.90 in FY 1989. An additional $4 per month was designated to the catastrophic health insurance Trust Fund.

Ensuring Quality of Care

Utilization and Quality Control Peer Review Organizations (PROs) under the aegis of HCFA concentrated on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). For every case retrospectively reviewed, PROs review to determine that: the quality of care met professionally recognized standards of care; the beneficiary was not prematurely discharged; if surgery was performed, the surgery was medically necessary; the admission was medically necessary and occurred in the most appropriate setting; and that the DRG coding was accurate. Major areas reviewed by the PROs included readmissions, transfers, and day and cost outlier cases. PROs also conducted prior authorization review of 10 procedures and reviewed outpatient surgeries.

Data submitted as of December 1989 for the period October 1988 through September 1989 indicated that PROs identified 8,656 physicians and 511 hospitals with quality-of-care problems. Of these PROs further cited 332 physicians and 57 providers for potential substantial or gross and flagrant violations of Medicare standards. During the same period, PROs reported that 486,154 discharges failed one or more of HCFA-provided generic quality screens and 6,991 Medicare patients were discharged prematurely or were readmitted or transferred for care that should have been provided during the first admission.

Encouraging Competition and Choice

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by expanding the availability of prepayment health plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). By the end of the fiscal year the number of HMOs and CMPs under contract with HCFA had increased to 195 and the number of beneficiaries enrolled in prepayment plans rose to 1.8 million.

During FY 1989, HCFA conducted site visits, and established a standard protocol for monitoring the activities of all federally qualified HMOs and organizations with Medicare contracts.

Demonstration Projects

In FY 1989, HCFA conducted a number of demonstration projects to explore methods to improve and refine the Medicare managed care program. Some topics addressed were a demonstration project to study diagnostic cost groups, a program to explore the feasibility of the employer-at-risk capitation concept, and a demonstration project testing whether the preferred provider organization concept can be applied to Medicare.

Distribution of Claims

Medicare intermediaries received 76.3 million claims in FY 1989, a 6.0 percent increase over FY 1988; Medicare carriers received 411.2 million claims, for an 8.7 percent increase.

Medicare Secondary Payer Provisions

The Medicare Secondary Payer (MSP) provisions, which cost $71 million to administer, produced more than $2.2 billion in savings

in FY 1989, for a cost-benefit ratio of 31:1. The provisions determine when Medicare is a secondary payer and another insurer is the primary payer of a Medicare beneficiary's claims for covered medical services and supplies.

Payments Limited to Hospitals for Diagnostic Procedures

HCFA implemented Section 9343 of OBRA 86 which enacted Section 1833(i)(3) of the Social Security Act to place a payment limitation on hospitals for certain diagnostic procedures. Payment for these procedures must be based, in part, on what Medicare would have paid for the same procedures had it been performed in a physician's office.

Other Reimbursement Policy Issues

Both Part A and Part B Medicare contractors were required to pay at least 95 percent of all "clean" claims within 25 days, 95 percent of all claims within 60 days and 99 percent within 90 days. By the end of the fiscal year nearly all contractors had met the claims processing timeliness (CPT) deadlines.

Beneficiary Services by Medicare Carriers and Intermediaries

During FY 1989, Medicare carriers handled 18,864,839 beneficiary inquiries, while Medicare intermediaries handled 1,812,757. In addition, carriers handled 8,475,714 provider inquiries while intermediaries handled 1,797,981.

Fee Schedules for Durable Medical Equipment (DME) and Oxygen for Institutional Providers

HCFA implemented a fee schedule for DME and oxygen furnished by institutional providers. Intermediaries use fee schedules that carriers develop for payment of these items. Payment based on the schedule is considered to be a final payment to providers and is not adjusted at cost report settlement.

Payment Limited to Hospitals for Radiology and Diagnostic Procedures

HCFA implemented Section 9343 of OBRA 86 which places a payment limitation on hospitals for radiology and certain diagnostic procedures. Payment for these procedures must be based, in part, on what Medicare would have paid for had it been performed in a physician's office.

Electronic Claims

More than 54 million Medicare claims processed by intermediaries and about 140 million processed by carriers were transmitted electronically during the fiscal year.

Replacement Contracts

Prudential Insurance Company announced its intention not to renew its Medicare contract. Transition of these large and varied workloads to new carriers was accomplished on schedule and Prudential left the Medicare program as of January 1, 1989.

Contractor Performance Evaluation Program

The Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. Twenty-four Part A standards and 27 Part B standards were applied during FY 1989 to evaluate contractor performance with regard to payment safeguards. Fifty of 55 intermediaries and 33 of 49 carriers passed the CPEP in FY 1989.

Carrier Medical Review

Carriers perform comprehensive postpayment review of providers whose practice patterns suggest overutilization. HCFA implemented a complete revision of the postpayment process in FY 1989. The new process enables carriers to better initially target providers for comprehensive review. The comprehensive reviews look at a 6 month snapshot of services, including both claims

and supporting medical records. Over 4,500 such reviews were completed in FY 1989.

Development of Automated Systems

HCFA implemented the System Tracking for Audit and Reimbursement (STAR). The system maintains audit and reimbursement data which enable all fiscal intermediaries to submit consistent and timely data to HCFA. The output report to the system is the Contractor Auditing and Settlement Report (CASR). Fifty contractors submit the CASR electronically to HCFA Data Center four times a year. This initiative enables HCFA to get closer to the goal of consolidating its data files used for all contractor/HCFA reports.

Medicare Heart Transplant Centers

Designated during the fiscal year as Medicare heart transplant centers were the Baptist Medical Center, Oklahoma City, OK; Los Angeles Medical Center, Los Angeles, CA; University of Washington, Seattle, WA; Carolinas Heart Institute, Charlotte, NC; Columbia-Presbyterian Medical Center, New York, NY; Sharp Memorial Hospital, San Diego, CA; M.S. Hershey Medical Center, Hershey, PA; and Hartford Hospital, Hartford, CT.

Research, Demonstrations and Evaluations

Research, demonstration, and evaluation projects were conducted during the fiscal year to test new reimbursement coverage, eligibility and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on health costs, program expenditures, beneficiary access to quality health care services, and the economics of the health care industry. Besides funding various intramural projects, HCFA spent nearly $48 million in FY 1989 for research and demonstration (R&D) grants and contracts in seven program areas.

Hospital Cost Reporting Demonstration Project in California and Colorado

The implementation phase of the uniform hospital cost reporting demonstration project began for cost reporting periods beginning on or after July 1, 1989. All participating hospitals in the states of California and Colorado are required to submit their Medicare cost report (Form HCFA-2552-89) and their demonstration cost report worksheets (Form HCFA-2552-DEMO) in a standardized electronic format. Under the electronic format, hospitals submit raw input data to their fiscal intermediaries on a diskette. The affected intermediary systems will accept that diskette, perform certain edit and desk review checks, and compute a cost report. In the past, when intermediaries received a cost report (calculated electronically by commercial vendor software) they had to re-enter all of the input data into their electronic system.

Promoting Internal Improvements

HCFA management accomplishments during the year included the adoption of the Project to Redesign Information Systems Management, a computer system to organize its data and improve the accuracy, accessibility, and timeliness of information; efforts to promote health, wellness, and fitness awareness and program utilization among HCFA employees; and an intensified effort to attract highly qualified job applicants. FY 1989 departmental procurement preference and competition goals were also exceeded in the awarding of more than $1.3 billion in contracts.

Validation Surveys of Hospitals

The purpose of the Medicare validation program is to determine the effectiveness of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation process in providing reasonable assurance that hospitals comply with the intent of

the Medicare conditions of participation. Each year a statistical sample of the approximately 5,200 JCAHO-accredited hospitals is selected for validation surveys. Under contract with the Secretary of Health and Human Services (HHS), State agencies (SAs) conducted 155 validation surveys during the fiscal year.

HCFA's validation analysis was conducted in two areas: Life Safety Code (LSC) and general health and safety requirements. The LSC of the National Fire Protection Association is a consensus standard adopted by reference in Federal regulations that provides a reasonable level of safety from fire and emergencies. During FY 1989, 29 percent (45 of 155) of validated hospitals were in compliance with general health and safety conditions.

In addition to the surveys conducted at selected hospitals, other accredited hospitals are subject to an SA survey when there is an allegation that significant deficiencies threaten the health and safety of their patients. For this report period, 582 hospitals received allegation investigations, and 10 percent (57 of 582) were found out of compliance with one or more conditions.

Medicare Supplement Insurance

HCFA continues to monitor the compliance of applicable State statutes and regulations with the minimum standards contained in the Federal law on Medicare supplement or "Medigap" insurance. These standards, developed by the National Association of Insurance Commissioners (NAIC) and incorporated by reference into Federal law, are intended to provide minimum benefits and protections for individuals who wish to purchase private health insurance to supplement their Medicare coverage.

In addition, the Federal law provides criminal penalties for certain fraudulent or abusive marketing practices. HCFA screens complaints received from consumer organizations, individuals, and other Government agencies and refers actionable cases to HHS' Office of Inspector General (OIG) or to the appropriate State insurance department, or to both, for investigation and prosecution.

HCFA was informed of eight possible violations of the penalty provisions in FY 1988 and seven in FY 1989. All of these cases were closed out due to either a lack of evidence or referral to specific State insurance departments for investigation of possible violations of State laws.

Medicare Catastrophic Coverage Act of 1988

HCFA implemented the Part A provisions of the Medicare Catastrophic Coverage Act effective January 1, 1989.

Table 1

MEDICARE TOUCHES MORE AND MORE PEOPLE: ONE OUT OF EIGHT HAS SOME MEDICARE COVERAGE OVER 95 PERCENT OF THE U.S. MEDICARE POPULATION IS ENTITLED TO BOTH HI AND SMI

PROGRAM COVERAGE	ALL AREAS			U.S.			POSSESSIONS & TERRITORIES			FOREIGN COUNTRIES		
	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED
HI and/or SMI[1]	33,597	30,409	3,171	32,886	29,821	3,065	423	337	92	264	250	14
HI	33,040	29,869	3,171	32,347	29,282	3,065	428	336	92	260	250	14
SMI	32,099	29,216	2,883	31,775	28,944	2,831	281	232	48	44	40	3
HI and SMI	31,669	28,667	2,883	31,237	28,406	2,831	280	231	48	44	40	3
HI only	1,481	1,192	288	1,111	876	234	149	105	44	216	211	10
SMI only	539	539	(2)	538	538	(2)	1	1	(2)	(2)	(2)	(2)

[1] Unduplicated count of persons enrolled in one or both parts of the Medicare program
[2] Less than 500

Table 2

PERCENTAGE OF DISTRIBUTION

PROGRAM COVERAGE	ALL AREAS			U.S.			POSSESSIONS & TERRITORIES			FOREIGN COUNTRIES		
	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED
HI and/or SMI	100	100	100	100	100	100	100	100	100	100	100	100
HI	98 3	98 2	100	98 4	98 2	100	99 5	99 7	100	100	100	100
SMI	95 5	96 1	90 9	96 6	97 1	92 4	65 3	68 8	52 2	16 3	16	21 4
HI and SMI	94 02	94 3	90 9	95 0	95 3	92 4	65 1	68 5	52 2	16 3	16	21 4
HI only	4 4	3 9	9 1	3 4	2 9	7 6	34 7	31 2	47 8	83 7	4 4	71 4
SMI only	1 6	1 8	0	1 6	1 8	0	0 2	0 3	0 0	0 0	0	0

Table 3

MEDICARE BENEFIT PAYMENTS SHIFT TO PART B SERVICES

FISCAL YEAR	TOTAL MEDICARE	TOTAL HOSPITAL INSURANCE	TOTAL MEDICARE	INPATIENT SNF	HHA	HOSPICE	TOTAL SUPPLEMENTARY MEDICAL INSURANCE	PHYSICIAN AND INDEPENDENT LABORATORY	OUTPATIENT
BENEFIT PAYMENTS IN MILLIONS									
1989	94,170	57,231	52,200	2,785	2,535	211	36,867	27,272	7,307
1988	85,540	51,858	48,770	712	2,239	137	33,682	25,218	6,452
1987	79,750	49,813	46,830	616	2,263	104	29,937	22,772	5,780
1986	74,036	48,867	46,034	579	2,186	68	25,169	19,248	4,920
1985	69,518	47,710	44,988	570	2,118	34	21,808	17,281	3,903
1984	60,934	41,461	39,080	536	1,841	4	19,473	15,449	3,534
1983	55,589	38,102	36,075	511	1,516	0	17,487	13,708	3,346
PERCENT DISTRIBUTION									
1989	100	60 8	55 5	3.0	2.7	0 22	39 2	29	7 8
1988	100 0	60.6	57 0	0 8	2.6	0 16	39 4	29 5	7 5
1987	100 0	62 5	58.7	0 8	2.8	0 13	37 5	28 6	7 2
1986	100.0	66.0	62.2	0 8	3.0	0 09	34.0	26 0	6.6
1985	100 0	68.6	64 7	0 8	3 0	0.05	31.4	24 9	5 6
1984	100 0	68.0	64.1	0 9	3 0	0 01	32.0	25 4	5 8
1983	100.0	68.5	64.9	0 9	2.7	0 00	31.5	24 7	6 0
BENEFIT PAYMENTS PER ENROLLEE									
1989	2,802	1,732	1,580	84	77	6	1,149	850	228
1988	2,594	1,600	1,505	22	69	4	1,065	798	204
1987	2,461	1,564	1,470	19	71	3	960	731	185
1986	2,332	1,565	1,475	19	70	2	823	629	161
1985	2,237	1,560	1,471	19	69	1	727	576	130
1984	2,001	1,382	1,303	18	61	0	662	525	120
1983	1,851	1,288	1,219	17	51	0	604	473	115
PERCENT CHANGE IN BENEFIT PAYMENTS FROM PRIOR YEAR									
1989	8 0	8 3	5 0	283.7	11 1	51.1	7 8	6 5	11 6
1988	5.4	2.3	2.3	13 6	-2 8	29.5	10.9	9 2	10 0
1987	5.5	-0 1	-0 3	4 3	1 5	49.9	16.7	16 1	15 3
1986	4 3	0.4	0.3	-0.5	1.1	96.0	13.1	9.2	23 6
1985	11.8	12.8	12.9	4.3	12.8	733.5	9 8	9 7	8 3
1984	8 1	7 3	6.9	3.5	19.8	N/A	9.7	11.0	4 0
1983	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SOURCE: OACT

Chapter I

The Medicare Population and Benefits

Introduction

Medicare enrollment increased 1.8 percent during FY 1989, from 33 to 33.6 million, and benefit outlays rose 10.1 percent, from $85.5 billion to $94.2 billion.

Medicare Beneficiaries

The Medicare rolls experienced a net increase of 599,000 individuals during the year. Some 2.07 million of the new enrollees were 65 years of age older, bringing to 30.4 million the number of elderly beneficiaries, and 360,000 were younger disabled persons, increasing the number of disabled beneficiaries to 3.2 million. Included among the disabled were 58,500 with end-stage renal disease who must meet eligibility requirements different than those for other disabled beneficiaries.

Of the 33.6 million beneficiaries, 32.9 million were residents of one of the 50 States or the District of Columbia, 421,000 resided in Puerto Rico, 7,000 in the Virgin Islands, 1,000 in Guam, and 255 in American Samoa, the Northern Mariana Islands and other outlying areas. Another 264,000 resided in foreign countries. Ninety-five percent of the Medicare population in the 50 states and the District of Columbia, 65 percent of the beneficiaries in U.S. commonwealths and territories, and 16 percent of the beneficiaries in foreign countries were enrolled in both Medicare Part A and Part B.

Women accounted for 57.8 percent of the total Medicare population, 60 percent of the eldest beneficiaries and 36.9 percent of the disabled enrollees. The percentage of disabled men, while down slightly in FY 1989 to 63.1 percent, has remained relatively constant since FY 1980 as has the percentage of aged who are men.

Minorities represent a growing proportion of the Medicare population. In FY 1989, 3.7 million Medicare enrollees were other than white. This represented 10.9 percent of the Medicare population, a rise of 0.3 percent over FY 1988 and an increase of 1.3 percent over FY 1980 when 9.6 percent of beneficiaries were non-white. While non-whites made up only 9.8 percent of aged beneficiaries, 21.0 percent of the disabled beneficiaries were other than white, an increase of nearly 1 percent over the figure for the previous fiscal year.

A significant demographic trend that has and will continue to affect Medicare is the increasing median age of beneficiaries. In FY 1973, 1.7 million beneficiaries, or 7.9 percent of the elderly population, were 85 and older. In FY 1989, 3.2 million or 10.5 percent of the aged population, were in the 85-and-over category. The aging of the Medicare population is an important economic factor as older beneficiaries generally require greater and more intensive health care services than do younger beneficiaries.

Benefit Expenditures

Medicare benefit payments for the fiscal year totaled $94.2 billion, or about $8.7 billion more than for FY 1988. Medicare benefit payments for FY 1989 were broken down as follows:

- Hospital Insurance (Part A), $57.3 billion
- Supplementary Medical Insurance (Part B), $36.9 billion

Table 4

BENEFIT	FY 1988	FY 1989	%CHANGE
Inpatient Hospital	$48,770	$52,200	7.0
Skilled Nursing Facility	712	2,785	220.9
Home Health	2,239	2,535	13.2
Hospice	137	211	54.0

Hospital Insurance

Part A spending, which was 10.7 percent higher than in FY 1988, was divided among its components as shown in Table 4.

While spending for skilled nursing facilities and hospice care grew at a much faster rate than in FY 1988, spending for inpatient hospitals and home health grew more slowly.

Supplementary Medicare Insurance

Part B, which at $36.9 billion, was 9.5 percent higher than in FY 1988, was broken down as shown in Table 5.

As was the case in the last fiscal year, the largest increases in terms of expenditures were for physicians and outpatient services. The rate of growth in the cost of physician services in FY 1989 slowed by nearly 3 percent from FY 1988, while the rate of growth in expenditures for outpatient services grew by nearly 2 percent.

Hospital Services

Of all purchases, hospital care accounted for the largest portion of Medicare spending in FY 1989. Nearly 56 percent of Medicare's total benefit expenditures and 91 percent of Part A outlays went for inpatient hospitalization. Admissions were down .2 percent and days of care leveled of to 8.8 days. During calendar year 1989, under the Medicare Catastrophic Coverage Act of 1988, the benefit period was suspended, and Medicare paid for an unlimited number of hospital days for covered services.

Skilled Nursing Facility Services

Medicare paid $2.785 billion for skilled nursing facility (SNF) services in FY 1989, the greatest percentage increase, or 221 percent more than in the last fiscal year. Medicare beneficiaries are entitled to 100 days of covered care during a benefit period in a skilled nursing facility after an inpatient hospitalization of at least three consecutive days, provided certain conditions are met each calendar year. During calendar year 1989, catastrophic coverage was in effect, and Medicare covered up to 150 days of skilled nursing care services. Coinsurance of $25.50 per day applied only to the first eight days.

Table 5

BENEFIT	FY 1988	FY 1989	% CHANGE
Physicians	$24,243	$26,176	8.0
Outpatient Services	6,452	7,307	13.3
Group Practice	1,952	2,218	13.6
Independent Laboratory	975	1,096	12.4
Home Health	60	70	16.7

Home Health Services

The $2.5 billion spent on home health services during the fiscal year was 13.2 percent higher than in FY 1988 and accounted for about 4.8 percent of Part A spending. Part A covers home health visits with no prior hospitalization requirement. The care needed must include part-time or intermittent skilled nursing care, physician therapy or speech therapy, and the patient must be confined to home.

Hospice Services

The second greatest percentage increase of Medicare spending during FY 1989 was for hospice care, which increased 54 percent, from $137 million in FY 1988 to $211 million. The rise was primarily due to the growing popularity of hospice care. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

Physician Services and Medical Supplies

Expenditures for physician services totaled $27.2 billion for the fiscal year. This was 7.9 percent higher than the FY 1988 outlay and represented nearly 71 percent of Part B spending for the year. Part B pays 80 percent of Medicare-approved charges for medical services after the beneficiary pays the first $75 in approved charges each calendar year.

Outpatient Services

Medicare spending for outpatient services rose 13.3 percent over FY 1988, increasing from $6.5 billion to $7.3 billion. Outpatient services provided by hospitals are covered under Part B.

Group Practice Plans

Part B expenditures for group practice plans increased from $1.952 billion in FY 1988 to $2.2 billion in FY 1989, or 13.6 percent. This was the second highest percentage increase of a Part B component and reflects the increased number of Medicare beneficiaries enrolled in prepayment plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs).

Independent Laboratories

Spending for independent laboratory services under Part B increased 12.4 percent, from $975 million in FY 1988 to $1.1 billion.

Home Health Care

Because most home health care is covered by Medicare Part A, only a small amount of such care is provided under Part B. Part B spending for home health care totaled $70 million in FY 1989, an increase of 16.7 percent from the previous year.

Hospitals

The number of short stay hospitals declined from 5,800 in FY 1988 to 5,582 in FY 1989. (Table 6).

Skilled Nursing Facilities

The number of SNFs rose from 7,507 to 8,198 in FY 1989, and the number of SNF beds increased by about 5,500 to 493,000 (Table 7).

Home Health Agencies

After decreasing to 5,688 in FY 1988, the number of home health agencies decreased again to 5,546 in FY 1989.

Other Providers

Other providers participating in Medicare during the fiscal year included 4,613 independent laboratories, 1,875 end-stage renal disease (ESRD) facilities, 170 comprehensive outpatient rehabilitation facilities, 1,096 ambulatory surgical centers and 703 hospices.

Table 6

AFTER PERIOD OF SLOW GROWTH, NUMBER OF BEDS CONTINUES TO DECREASE IN 1989

	1975	1980	1985	1987	1988	1989
Total Hospitals	6,773	6,777	6,707	6,677	6,687	6,508
Beds (in thousands)	1,140	1,150	1,144	1,177	1,118	1,103
Beds per 1,000 Enrollees	51.7	46.7	42.5	41.3	39.1	38.0
Short-Stay	6,107	6,104	6,034	5,872	5,800	5,582
Beds (in thousands)	902	991	1,027	1,038	991	973
Beds per 1,000 Enrollees	40.9	40.2	38.2	36.4	34.7	33.5
Psychiatric	385	408	474	604	604	636
Beds (in thousands)	199	131	95	115	94	96
Beds per 1,000 Enrollees	9.0	5.3	3.5	4.0	3.3	3.3
Other Long-Stay[1]	281	265	199	201	283	290
Beds (in thousands)	40	28	22	24	33	34
Beds per 1,000 Enrollees	1.8	1.1	0.8	0.9	1.2	1.2

[1] Beginning October 1, 1983 a number of short-stay pediatric, rehabilitation, and alcohol/drug hospitals were re-assigned non-short-stay provider numbers and are included in this category for 1985-1989.
NOTE: Counts are as of July 1.

Table 7

STRONG GROWTH IN MOST PROVIDERS OF ALTERNATIVE CARE

	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1989
Skilled Nursing Facilities	5,295	5,052	6,451	7,262	7,507	8,198
Beds (thousands)	287	436	n/a	845	456	491
Home Health Agencies	2,242	2,942,	5,679	5,887	5,688	5,546
Independent Laboratories	3,048	3,447	3,980	4,381	4,571	4,613
ESDR Facilities	-	999	1,393	1,644	1,755	1,875
Outpatient Physical Therapy	117	419	845	977	1,044	1,082
Portable X-Ray	132	216	308	374	409	418
Rural Health Clinics	-	391	428	451	450	484
Comprehensive Outpatient Rehabilitation Facilities	-	-	72	124	146	170
Ambulatory surgical Centers	-	-	336	765	950	1,096
Hospice	-	-	164	390	522	703

NOTE: Facility data are as of July 1.
Data: Not available
-: Not applicable

Program Funding

The primary source of Part A financing (89.2 percent) was derived from payroll taxes paid by workers and their employers and by self-employed individuals. The remaining 10.8 percent came from Federal general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B is financed by three sources:

(1) premium payments from enrollees,

(2) contributions from general revenues, *and*

(3) interest on trust fund reserves. Under amendments enacted by the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act, the Part B premium is set at 25 percent of program costs. In FY 1989, beneficiary premiums accounted for 24.7 percent, and government contributions 72.9 percent of Part B income. Interest on trust fund reserves covered the remaining percent. In addition, in FY 1989 the Medicare Catastrophic Coverage Act of 1988 (MCCA) provided for payment of a $4 premium added to the monthly Part B premium of $27.90.

More detailed information about the status of the trust funds, showing income, disbursement and future projections, is contained in the 1989 Annual Reports of the Board of Trustees for the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund.

Chapter II

Ensuring Quality of Care

Introduction

One of the priorities in FY 1989 was to place further emphasis on the quality of care provided to Medicare patients by certified providers. The intent was to promote and ensure effective and efficient delivery of all necessary medical services to beneficiaries. As in past years, Utilization and Quality Control Peer Review Organizations (PROs) were integral to the quality-assurance effort.

Peer Review Organizations

PROs are charged by law to assure that services rendered to Medicare beneficiaries are medically necessary, are provided in the most appropriate setting (e.g., acute care hospital versus skilled nursing facility or a lesser level of care), and meet professionally recognized standards of quality. The PRO program was created by the Peer Review Improvement Act of 1982, Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248.

PRO reviewers (usually nurses) use criteria/screens for review which are developed by local physicians to approve cases which clearly meet acceptable standards and to refer questionable cases to PRO physician reviewers. If, after review, and after affording the physician/provider an opportunity to discuss the case the PRO physician reviewer determines there is a quality problem, the PRO will initiate corrective action. If the PRO physician reviewer determines the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial. If, based on prior authorization review, the PRO determines a procedure is medically unnecessary, the request is denied and unnecessary surgery is prevented. Only a PRO physician reviewer may deny a case or confirm that there is a quality problem, but only after the attending physician and provider have been given an opportunity to discuss the case with the PRO. Also, whenever possible, PROs utilize physician reviewers whose specialty and practice setting are similar to those of the physician whose services are under review.

Quality Review Process

In the third PRO contract cycle continued emphasis was placed on the quality review process through a more structured approach, thus ensuring that PRO review was conducted consistently and that specific actions were taken to address identified quality problems. In stressing quality review, the following actions were taken:

- All PROs were required to apply a HCFA mandated quality intervention plan, which is a prescribed blueprint by which each PRO is required to perform quality review and implement interventions when quality concerns are identified.
- Retrospective invasive procedure review was also emphasized. In denying unnecessary surgeries, the PRO educated physicians and providers and helped to prevent further unnecessary surgeries.
- "Generic quality screens" were provided as a tool to assist in identifying potential quality problems and were required to be applied to each case undergoing retrospective review.
- Each case selected by the PRO for retrospective review was required to be examined for the appropriateness of the discharge.

PRO Review Performance

From October 1988-September 1989, PRO denials under the authority of Section 1886(f) (2) of the Act, for inappropriate discharges and transfers occurred in 6,682 cases for the following reasons:

- Premature discharge of an unstable patient that resulted in the subsequent readmission of the patient to the same hospital.
- Readmission of a stable patient to a hospital for care that could have been provided during the first admission.
- Inappropriate transfer from a PPS unit to a PPS-exempt unit in the same hospital or a transfer from PPS-exempt unit to a PPS unit in the same hospital.

Section 1886(f) (2) of the Social Security Act provides specific actions which may be taken when a hospital, in order to circumvent the PPS, has taken an action that results in unnecessary admissions, unnecessary readmissions, and other inappropriate medical practices. This authority was implemented by PROs in July 1985. The PROs deny payment for the second admission when: a premature discharge results in the subsequent readmission of the patient to the same hospital; or a patient is inappropriately transferred within the same hospital (e.g., the discharge of a patient from a psychiatric unit reimbursed on a cost basis to the PPS portion when the patient only requires the level of care provided in the psychiatric unit). These are not considered "quality of care" denials, although quality of care issues are involved and the PRO must take action to resolve the issues identified.

Fiscal Year 1989 Activity

During the year, HCFA has completed final revisions of the long term care survey process and accompanying forms and surveyor guidelines. Training of State and Federal survey staff, as well as provider, consumer and professional groups has been an integral part of the process of working toward an October 1, 1990 implementation of the new long term care requirements using the revised survey process. Related activities undertaken during the fiscal year included:

- The conduct of four major national training courses for Federal and State long term care surveyors, training approximately 1,200 individuals.
- Long term care staff participation in numerous training sessions for providers and surveyors.
- Issuance in the State Operational Manual of the survey procedures and guidelines for the new long term care requirements that were issued through regulation in February 1989 and that became effective October 1, 1990.

Report on Implementation of the New Long Term Care Requirements

Oversight of the care provided to Medicare and Medicaid beneficiaries residing in Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) is the responsibility of HCFA. This oversight is provided through the conduct of a survey at least once a year of each SNF and ICF participating in either the Medicare or Medicaid program.

Section 1864 of the Social Security Act requires the Secretary to enter into agreements with States to survey skilled nursing facilities to determine whether they are in compliance with Medicare participation requirements as set forth in Section 1819 (b) -(d) of the Act. Section 1902 (a) (33) (B) of the Act requires the State Medicaid agency to contract with the State survey agency used by Medicare (if they are responsible for licensing health facilities), to determine whether nursing facilities meet the requirements for participation in the Medicaid program.

Applicable survey requirements and procedures for Medicare participating facilities are described in Subpart S of 42 CFR, Part 405, while Subpart C of 42 CFR, Part 442 provides that information for Medicaid participating facilities.

Passage of OBRA 87 initiated many changes in the requirements to be met by long term care facilities participating in both Medicare and Medicaid (new requirements for long term care facilities were published on February 2, 1989 and codified in 42 *CFR* part 488). This legislation, in concert with a report from the Institute of Medicine in 1986, has caused HCFA to revise the long term care survey process. Over the last several years, HCFA, with the advice and assistance of many professional and consumer groups, the long term care industry, and other interested parties, has developed a new long term care survey process. It is oriented toward evaluating the outcome of resident care rather than the administrative and structural abilities of a facility to deliver care.

Chapter III

Encouraging Competition and Choice

Introduction

HCFA continued during the fiscal year to place emphasis on providing Medicare beneficiaries with a choice of enrolling in prepayment health plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). Prepayment plans are increasing in popularity among Medicare beneficiaries as an alternative to the traditional fee-for-service system for the delivery of health care services. The Medicare program has been contracting with HMOs since 1972, and in 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) expanded the types of organizations eligible to enter into Medicare contracts to include CMPs. HMOs and CMPs may contract with HCFA to be paid on either a risk or reasonable cost basis.

In FY 1989, HCFA contracted with 195 HMOs, CMPs, and health care prepayment plans (HCPPs) to provide managed, coordinated health care to over 1.8 million Medicare beneficiaries. The majority of these beneficiaries were provided additional benefits not covered by traditional fee-for-service Medicare, including, for example, preventive care services, unlimited hospital days, and in certain competitive markets, the provision of prescription drugs and eyeglasses.

HMO/CMP Oversight

HCFA is responsible for monitoring the activities of all federally qualified HMOs and organizations with Medicare contracts to assure these organizations comply with existing law. HCFA monitors contractors by conducting site visits to assess the regulatory and contractual requirements relating to the contractor's overall operations, as well as its ongoing capability of carrying out the Medicare contract.

To enhance this process, HCFA improved its internal compliance operations by developing uniform procedures. HCFA further organized its monitoring activities to establish a standard protocol for monitoring national HMO chain organizations. In addition, HCFA conducted site visits to assess regulatory and contractural requirements related to the contractor's overall operations, as well as its ongoing capability of carrying out the Medicare contract.

Beneficiary Inquiry Tracking System (BITS)

In 1987, The Beneficiary Inquiry Tracking System (BITS) was developed to monitor the handling by prepayment plans of the inquiries and problems of Medicare members. During 1989, HCFA improved BITS so that the program will facilitate Regional office staff efforts to focus compliance activities on specific HMOs/CMPs. BITS was also updated to ensure a prompt response to beneficiary questions and/or complaints.

Plan Information Control System (PICS)

In June 1989, HCFA implemented the first phase of the plan information control system (PICS). PICS was conceived as an automated data base of plan-specific information which would be easily accessible to the applicable HCFA components.

Final implementation satisfied many of HCFA's objectives: Medicare contract data was automated and integrated with Federally qualified HMO data; converted CMP data from a personal computer file was transferred to a shared, multi-user environment and integrated with the Federally qualified HMO data; HMO and CMP financial data, which

were part of the National Data Reporting Requirements (NDRR) database, were integrated with other demographic data for Federally qualified plans and Medicare contracts; and HMO/CMP data was made accessible to staff through microcomputers.

Disenrollment Survey

In FY 1989, HCFA initiated a survey of beneficiaries who had disenrolled from contracting health plans. The survey was conducted in order to determine the factors that cause beneficiaries to disenroll from a health plan. A report on the findings of the survey of 17,000 beneficiaries will be prepared.

HMO/CMP Reconsideration Process

In FY 1989, HCFA awarded a contract to Network Design Group (NDG) to conduct reconsiderations of Medicare claim denials made for beneficiaries in HMOs/CMPs. After HCFA staff trained NDG in the established policies and procedures for conducting reconsiderations, NDG began reviewing cases in February 1989.

Demonstration Projects

In FY 1989, HCFA conducted a number of demonstration projects to explore methods to improve and refine the Medicare managed care program.

Diagnostic Cost Groups (DCG) — In 1989, HCFA initiated a demonstration to study diagnostic cost groups. Contractors had expressed concern that the current risk payment methodology, the Adjusted Average Per Capita Cost (AAPCC), does not incorporate an adjustment to reflect the health status of Medicare enrollees. The DCG methodology is a proposed payment system for Medicare HMOs/CMPs that could prove to be an improvement over the AAPCC payment methodology.

Medicare Insured Groups — Another item on HCFA's evaluation agenda is a demonstration program to explore the feasibility of the employer-at-risk capitation concept. This concept would allow direct contracts between HCFA and unions, insurers, and other organizations that are responsible for the provision of health care coverage to Medicare eligible beneficiaries. These organizations are referred to as a Medicare insured group (MIG) sponsor.

Under the MIG demonstration, HCFA would pay the MIG a monthly rate for each Medicare beneficiary enrolled in the managed care plan sponsored by the MIG. The sponsoring employer or union would then assume responsibility for providing or arranging all Medicare-covered benefits to the beneficiaries in the group.

For retirees, the MIG offers an expanded choice of health benefit plans and the possibility of extra benefits at no additional cost. It also permits active employees to join a managed care system and continue in the same health plan without interruption upon retirement. For the government, reimbursement to MIGs is cost effective because the payment rate is set at five percent less than what Medicare would otherwise pay on a fee-for-service basis.

Preferred Provider Organizations (PPO) —During FY 1989, HCFA initiated the development of a Medicare Preferred Provider Organizations (PPO) demonstration project. The purpose of the demonstration is to test whether the PPO concept can be applied to Medicare. A PPO is an entity that makes health care services available through a network of providers who agree to provide their services to PPO members at a discount. A PPO may help to reduce Medicare program costs through its ability to control utilization of health care services. For Medicare beneficiaries, PPO premiums are traditionally lower than premiums for Medigap policies,

and, unlike a Medicare risk-based HMO or CMP, Medicare program payment can still be made when the individual chooses to receive care from a non-PPO provider.

Managed Care Initiatives

Employer Group Task Force — The Task Force, comprised of representatives from various components within HCFA, gathered information from HMOs and CMPs currently contracting with employer groups. Many employers purchase health care coverage for their retires from HMOs that have Medicare contracts with HCFA. The Task Force met with industry leaders and business groups to learn more about current practices involving Medicare-group retirees, and conducted site visits to HMOs to study the extent of their difficulties in serving group retirees. A package of proposals and recommendations is being prepared by the Task Force to facilitate employer group contracts with Medicare-contracting prepaid health plans.

Redesign of the Group Health Plan System — The system used by HCFA to process prepayment plan enrollment and disenrollment data, the Group Health Plan (GHP) system was designed more than 15 years ago. In 1989, HCFA initiated a major redesign of the GHP system. Phase I of the redesign began in 1989, and is scheduled for completion in November 1990. Full implementation of all three phases is expected to be completed in January 1992. The redesign will improve access to Medicare data for HCFA staff, allow for more frequent submission of enrollment/disenrollment data by health plans directly to HCFA through electronic media, and provide for electronic media transfer of HCFA information to contracting health plans in lieu of mailing hard copies.

Legislation Affecting HMOs and CMPs

The Medicare Catastrophic Coverage Act contained a number of provisions relating to HMOs and CMPs. HCFA spent a substantial amount of time developing the proposed rules for implementation.

The Act established an administrative structure known as the "buy-out test" for HMOs to implement the Medicare Part B catastrophic benefits beginning in 1990. The purpose of the buyout was to ensure that Medicare beneficiaries who disenrolled from an HMO could return to fee-for-service and receive credit for expenses they incurred while enrolled in a prepaid plan.

HCFA also prepared draft rules that specified proxies for HMOs/CMPs to use in identifying those beneficiaries that would be eligible for respite care benefits in 1990.

Adjusted Community Rate (ACR Process

The benefits a risk-based HMO/CMP will offer in a given contract year, and the charges it may impose on Medicare members, are determined through the ACR process. The ACR process involves the risk-based contractor submitting an ACR proposal, or the revenue requirements of the plan for providing all Medicare-covered services to the Medicare members it expects to enroll in the coming year, to HCFA. During FY 1989, HCFA streamlined the ACR process by incorporating the operation into personal computer software for the convenience of both contracting plans and HCFA staff. HCFA also developed a data base to assist in the determination of reasonableness of selected ACR data submitted by a plan. Variances between the data base and the figures submitted by the plan must be explained if the variance falls outside the parameters established by HCFA.

Chapter IV

Efficient Operation of Medicare

Introduction

Medicare contractors fulfill the Federal Government's responsibility of reimbursing Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Fiscal intermediaries reimburse providers of services under Part A of the Medicare program, primarily for hospital inpatient activities. Their responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding the Medicare trust funds against payment for services that are not medically necessary. Carriers adjudicate claims and make payments to beneficiaries and providers of service under Part B of the Medicare program, primarily for physician services. Their responsibilities include receiving and accounting for Medicare benefit claims, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining allowable reasonable charges for medically necessary covered services, and computing and recovering overpayments in cases of erroneous payment. They also implement the participating physician program, establish methods to identify utilization patterns which deviate from medically accepted norms and report such deviations to the appropriate professional groups.

Distribution of Claims

Intermediaries received 76.3 million claims in FY 1989, a 6.0 percent increase above the FY 1988 level. The majority of claims received by the intermediaries, 66.0 percent were for outpatient services. Inpatient hospital claims accounted for 15.0 percent of the claims received, while home health agency and skilled nursing facility claims accounted for 6.9 percent and 2.0 percent, respectively. The remaining 10.1 percent were claims submitted for ancillary and other miscellaneous services payable under Part B. The unit cost to process these claims was $1.79. Carriers received 411.2 million claims in FY 1989, an 8.7 percent increase over the FY 1988 level. The percentage of claims submitted by physicians and suppliers on assignment increased from 76.3 percent in FY 1988 to 79.3 percent in FY 1989. The unit cost to process these claims was $1.20.

Payment Safeguards

In addition to processing payment claims for providers of service and Medicare beneficiaries, contractors perform other vital functions. These include conducting medical reviews of claims to ascertain whether services are medically necessary and constitute and appropriate level of care, auditing Medicare cost reports of providers, and assuring that under certain circumstances, Medicare is the secondary payer of the health care services rendered a Medicare beneficiary when the services are covered by a private insurer. These payment safeguards accounted for savings of $4.0 billion for FY 1989 as follows:

Medical Review/ Utilization Review	$1.0 billion
Medicare Secondary Payer	$2.2 billion
Audit	$0.8 billion

National Malpractice Negotiated Settlement

HCFA successfully implemented the national malpractice negotiated settlement as well as the provisions of the Georgetown I and II court cases. This effort resulted in the development of detailed instruction packages, conducting national training sessions and monitoring progress to ensure successful implementation of the national malpractice negotiated settlement provisions. In addition, HCFA performed similar efforts to ensure that the HCFA Administrator's Ruling (HCFAR 89-1) pertaining to the Georgetown Court decisions were properly effected. Total payout to date has exceeded $246 million under negotiated agreement and $145 million under Georgetown. Although this effort resulted in substantial payout of Medicare funds, it resulted in an equitable payment/ settlement to over 4,100 hospitals, for approximately 14,200 cost reporting periods, as far back as 1980. These payouts represented principal, interest and revised PPS payments. It should be noted that without the instructions and training provided, many eligible and ineligible providers may have been overpaid to a significant degree.

Prospective Payment System (PPS) Refinements

FY 1989 PPS changes were implemented timely:

- New rates of increase in payment for inpatient hospitals services;
- Changes in the Medicare outlier threshold;
- Revisions of the Diagnosis Related Group classification and weighting factors;
- The establishment of regional floors for the PPS standardized payment amounts.

Medicare Secondary Payer (MSP) — Litigation

The MSP program, which cost $71 million to administer produced approximately $2.2 billion in savings in FY 1989, for a cost-benefit ratio of 31:1. The program is used to determine when Medicare is a secondary payer and another insurer is the primary payer of a Medicare beneficiary's claims for covered medical services and supplies. If we find evidence of intentional noncompliance with the MSP provision we refer the case to the Department's Office of General Counsel and the Office of Inspector General.

The Government filed three affirmative lawsuits against three insurance companies for violations of the MSP provisions involving employer health. The insurance companies are Blue Cross Blue Shield of Michigan, Provident Life and Accident, and The Travelers Companies. No decisions were reached in FY 1989 on these cases. Two cases involving challenges to HCFA's policies requiring hospitals to bill Medicare first in MSP liability situations were pending in FY 1989. A decision was reached in *Oregon Hospital Association v. Sullivan*. No decision was rendered in *American Hospital Association v. Sullivan*. The decision in the Oregon case overturned HCFA policy and determined that hospitals could bill liability insurers and file liens when liability insurers could be expected to pay promptly.

Implementation of Physician Registry

HCFA established the Physician Registry at Transamerica Occidental Life Insurance Company in Los Angeles, California and completed implementation of the physician identification system at all carrier sites. Carriers submitted physician records to the Registry, and the Registry matched the records against American Medical Association supplied records to corroborate the identity of medical doctors on the carriers' provider files. During the year, the Registry assigned Unique Physician Identification Numbers (UPIN) to over 492,000 physicians, including medical

doctors, doctors of osteopathy, doctors of dental medicine, dental surgeons, podiatrists, optometrists, and chiropractors. The agency is phasing in the use of UPINs in claims payment to facilitate tracking of program expenditures and physician practice patterns.

HCFA Wins Provider-Based HHA Lawsuit

In response to a May 19, 1988 final rule published in the *Federal Register* which authorized the assignment of provider-based HHAs to the designated regional home health intermediaries, 40 HHAs filed a lawsuit on September 28,1988 (New Britain General Hospital Home Health Agency, et al, versus Otis Bowen, Secretary, DHHS) against the Government with the U.S. District Court for the District of Columbia (D.C.). They were subsequently joined in the lawsuit by an additional 46 HHAs. The HHAs alleged that the Government failed to apply the proper standards, criteria and procedures designated to assure that the upcoming provider-based HHA transfers would result in the more efficient and effective administration of the Medicare program and that the Government applied criteria and standards which were improperly promulgated. On September 30, 1988 the judge for the U.S. District Court, D.C., denied the HHAs' request for a temporary restraining order and the provider—based HHA transfers began on October 1, 1988 as scheduled. On December 7, the Court handed down a decision in favor of HCFA.

Claims Processing Timeliness (CPT)

Congress established new policies in Section 9311 of OBRA 86 for the timely payment of Medicare claims. Both Part A and Part B contractors were required, as of the beginning of FY 1989, to pay at least 95 percent of all "clean" Medicare claims within 25 days. HCFA further required contractors to pay 95 percent of all claims within 60 days and 99 percent of all claims within 90 days. Carriers were required to pay 95 percent of clean claims submitted by physicians, agreeing to participate in Medicare in 18 days. Since April 1987 intermediaries and carriers failing to meet the CPT deadlines for clean claims have been required to pay interest on clean claims not paid within 25 days.

Section 4031 (a) of OBRA 87 included a payment floor provision which stated, in part, that all Medicare claims received on or after October 1, 1988 be held 14 days before payment could be made.

By the end of FY 1989 Part A and Part B contractors had achieved considerable success in complying with the CPT requirements. The requirement for paying at least 95 percent of all clean claims in 25 days was met by all but one intermediary and three carriers. The 18-day requirement for participating physicians was met by 8 of the 49 Part B contractors. All Part A contractors met the 60 and 90-day requirement. For Part B, all but two carriers met the 60-day requirement, three carriers failed to meet the 90-day requirement.

At the close of FY 1989, an analysis of payment floor data revealed that two intermediaries reported paying claims before the 15th day. A number of contractors had experienced systems problems in implementing the floor provision of OBRA 87. Through this analysis, HCFA identified several forms of corrective action for the contractor community to implement to resolve these isolated problems.

Contractor Performance Evaluation Program

HCFA uses the Contractor Performance Evaluation Program (CPEP) to evaluate the performance of its Medicare contractors. Numerous performance standards incorporated in the CPEP are designed to reduce inappropriate expenditures through payment safeguards. In FY 1989, 24 of the 62 total Part A standards and 27 of the 67 total Part B standards were designed to evaluate contractor

performance with respect to payment safeguards. Selected standards included Medicare Secondary Payer goals, cost effective medical review and/or audit programs, detection of fraud and abuse cases, limiting the incidence of provider overpayments and ensuring that no payments are made to excluded, terminated or suspended suppliers or physicians.

Fifty of 55 intermediaries and 33 of 49 carriers passed the CPEP in FY 1989.

Replacement Contractors

In April 1988 Prudential Insurance Company announced its intention to nonrenew its Medicare contracts effective December 1988.

For the Part A workloads, Blue Cross Blue Shield United of Wisconsin was selected to serve as the designated regional home health intermediary in the New York region, comprising New York, New Jersey, Puerto Rico, and the Virgin Islands. The New Jersey hospital and skilled nursing facility workloads were reassigned to Blue Cross and Blue Shield of New Jersey, Inc. and Aetna Life and Casualty Company.

For the Part B workloads, Pennsylvania Blue Shield was selected as the Medicare carrier for the State of New Jersey, Equicor Inc. as the carrier for the State of North Carolina, and Aetna Life and Casualty Company as the carrier for the State of Georgia.

Transition of these large and varied workloads was accomplished on schedule and Prudential left the Medicare program as of January 1, 1989.

Common Working File (CWF)

CWF is a decentralized Medicare claims validation and benefit authorization process. The fundamental objective is to simplify, speed, and improve Medicare claims processing. Host sites maintain beneficiary-specific files containing complete entitlement, utilization, and history data. All Part A bills and all Part B claims are processed against this single file. Contractor operations are simplified through the elimination or reduction of processes such as query/reply, admission notices, batch clearances, RTIs, and payment records. Enhanced protection for benefit funds is achieved, in part, through prepayment A/B history reviews, expansion of the base to check for duplicate claims, immediate Medicare Secondary Payer (MSP) status updates, and reductions in adjustment processing (and, thus, overpayment recovery actions).

In FY 1989, six of the nine CWF Host sites were operational. Eighteen Satellites were implemented: 13-Part A and 5-Part B contractors.

Shared Systems

HCFA's systems policy is to strongly encourage all Medicare contractors to enter into shared processing or shared maintenance arrangements. At the end of FY 1989 there were 22 intermediaries and 15 carriers, for a total of 37 contractors participating in shared systems arrangements.

Improve Home Health Review

In FY 1989, HCFA implemented a home health database. The information for the database is collected from the billing form and home health physician's plan of care and medical information forms. The data will be used by the nine regional home health intermediaries to focus medical review efforts on aberrancies and unusual practice patterns. Additionally data will be collected nationally for information on home health utilization.

Medicare Carrier Local and Toll-Free Telephone Service

Medicare carriers were reminded during the year of the importance of the requirement that they provide local and toll-free telephone service to Medicare beneficiaries. Carriers must meet busy signal and call acknowledgment standards for telephone service, and are required to install telephone monitoring

equipment to electronically monitor telephone service performance. Monthly reports of performance are required, and if a carrier does not meet minimum standards, corrective action is taken by the appropriate HCFA regional office. In FY 1989 carriers maintained an average of 11.2 percent all-trunks-busy (ATB) level of service against a standard of not more than 20 percent ATB.

Beneficiary Inquiry Workloads at Carriers and Intermediaries

During FY 1989, Medicare carriers handled 18,864,839 beneficiary inquiries (16,622,077 telephone, 1,831,241 written, and 411,521 walk-in). This represented a 12.7 percent increase in beneficiary inquiries over FY 1988. Carriers also handled 8,475,714 provider inquiries (5,185,532 telephone, 3,260,308 written, and 29,874 walk-in). This represented a 18.4 percent increase in provider inquiries over FY 1988. Beneficiary and provider inquiries in FY 1988 totaled 27,340,553.

Medicare intermediaries handled 1,812,757 beneficiary inquiries in FY 1989 (1,441,796 telephone, 330,779 written, and 40,182 walk-in) and 1,797,981 inquiries from providers (1,120,978 telephone, 676,142 written, and 861 walk-in). Beneficiary inquiries to intermediaries increased by 6.7 percent in FY 1989.

Denied Claims Review

After denial of Part A claim, a claimant has the right to reconsideration by the intermediary. During FY 1989 there were 39,770 reconsideration requests, a 36 percent decrease from the number of reconsiderations in FY 1988. If the claim is denied at the reconsideration level, the claimant may request a hearing before an administrative law judge.

For a denied Part B claim, a claimant has the right to a carrier review and, if the claim is again denied, a subsequent carrier hearing. In FY 1989, carriers received 6.8 million requests to review denied claims, an increase of 19 percent over FY 1988. Of those reviewed, 54 percent resulted in reversals. Carrier hearings requested during the fiscal year numbered 71, 967, an increase of 11 percent over the FY 1988 level. Forty percent of the hearings resulted in reversals. If the claim is denied at the carrier hearing level, the claimant may request a hearing before an administrative law judge.

Participating Physician Program

DEFRA 84 created the participating physician program under which physicians and suppliers may make a voluntary choice each year to accept assignment on all Medicare claims for the following year. Those who accept assignment agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. On assigned claims, they bill the beneficiary only for applicable deductible and coinsurance amounts.

For the most recent participating period, extending from January to December 1989, 40.7 percent of the physicians and 21.0 percent of the suppliers signed participation agreements.

Carrier Medical Review

Ensuring that Medicare payment is made only for reasonable and necessary physician services and other items is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment reviews of utilization patterns of physician and supplier services. The carrier determination is based on national coverage policy in association with local policy developed by the carrier medical staff. This activity has been cost effective, with FY 1989 program savings of about $6 for each administrative dollar expended.

Beginning in FY 1989, all carriers were required to have physician medical directors.

These physicians provide leadership in the development of medical review policy. Local medical policy development is an open and collaborative process with carriers obtaining comments from the State medical society and appropriate specialty societies prior to implementing new or changed policy. Policies are communicated in writing 30 days in advance of implementation to affected physicians. These activities have played a major role in improving local professional relations.

HCFA and the AMA worked collaboratively to produce an informative booklet entitled "Medicare Carrier Review." This booklet, now in its third printing, provides information to physicians on the Medicare carrier medical review process in an attempt to explain the carrier requirements. The booklet contains listing of carrier, State medical society and HCFA PRO contacts.

Automated Provider Debt Management Systems

HCFA operates and maintains automated systems that gather information on the actual amounts and causes of provider overpayments and associated interest, the recoupments, and the time associated with recovery. These systems utilize a nationwide telecommunications network linking HCFA's central office with its regional offices and contractors.

Provider Overpayments

The following figures reflect the activity in collecting overpayment made to Medicare Providers:

PART A

Starting Balance (10/1/88)	$399 million
New Overpayments	2.259 million
Collected	2.333 million
Ending Balance (9/30/89)	$325 million

PART B

Starting Balance (10/1/88)	$27.1 million
New Overpayments	75.6 million
Collected	75.6 million
Ending Balance (9/30/89)	43.2 million

Part A Quality Assurance Activities

In FY 1989, the Part A Quality Assurance Review Program examined the accuracy of inpatient PPS bill processing at 11 fiscal intermediaries (FIs). The program discovered and corrected erroneous situations at these contractors that would have caused an estimated $40.5 million in mispayments based on the error rates at the FIs reviewed.

The program was adapted to evaluate FI performance in handling deductibles and coinsurance before and after the Part A provisions of catastrophic coverage took effect on January 1, 1989.

We also continued a program to validate key data on the Provider Specific File, which is a critical element in calculating the PPS reimbursement to institutional providers. Efforts led to increased accountability for data accuracy on the part of the FIs as well as more effective monitoring of the validity of this key data by HCFA.

Part B Quality Assurance Activities

The Part B Quality Assurance (QA) Program operated at all carrier sites during FY 1989. The national payment error rate was 1.20 percent. This compares to a rate of 1.1 percent in FY 1988. Ten processing sites reduced their error rate by at least .3 of a percentage point from the previous year.

Several activities to improve quality assurance were initiated during the year. A new data system was implemented to replace an outdated QA system. The new system provides for greater flexibility and a complete data base for corrective action analysis, accessible to carriers, regional offices, and central offices staff. The system was implemented on July 1, 1989.

HCFA also implemented a computerized edit program to measure the accuracy of the annual reasonable charge update. The program was run twice during the year, first when the reasonable charge screens are initially updated, and secondly a rerun of the edits 6

months after the initial update to analyze any subsequent changes in the reasonable charge screens. Both passes of the edits detected over $13 million in potential mispayments for which immediate corrective action was initiated.

Uniform Contractor Evaluation Program (UNICEP)

The UNICEP is the primary instrument to evaluate the quality of Medicare contractor performance in the auditing and settling of Medicare cost reports (Hospitals, Home Health Agencies, Skilled Nursing Facilities and Chain Organizations). The final score from this program is incorporated into the Contractor Performance Evaluation Program to determine an evaluation of contractor performance in all aspects of their operations.

During FY 1989, a major restructuring of the program was undertaken to divide the program into two major components, add a program to review the management of the audit process, and to make the review programs more uniform in application and content. The areas in the program are:

- The management review program which evaluates contractor' compliance with audit management expectations as expressed by HCFA instructions and in the Government Auditing Standards.
- The engagement reviews that examine the quality of individual audit performance.

In addition, the method of sampling audits for reivew was changed to focus on areas of greatest vulnerability to the Medicare Program and to mirror the audit work completed by the contractors. During FY 1989, the regional offices performed 449 reviews and identified approximately $25 million in improper payments to Medicare providers.

Special Teaching Hospital Study

As a adjunct to the UNICEP a special study of 16 major teaching hospitals was conducted to investigate instances of possible inappropriate revenue enhancement through improper calculation of outpatient clinic services. The study disclosed that program instructions, billing and claims processing, and intermediary audit quality should be improved. Actual overpayments have not been finalized but it is estimated that the impact of the study is overpayments in excess of $20 million.

Major Chain Reviews

During FY 1989, HCFA staff performed evaluations of three major chain organizations to determine the accuracy and quality of the audits performed on the chains and the efforts on the chain's providers. The reviews determined a lack of quality in several areas of audit performance. The results also showed potential overpayments to individual providers in the three chains reviewed to be over $28 million.

Division of Operational Reviews

Operational reviews undertaken during the fiscal year included completing reviews on global service/fee packages for five surgical areas (cataract, Coronary Artery Bypass Grafts (CABG), Transurethal Resection Prostatectomies (TURP), hip reconstruction, pacemaker) and five other studies started in prior and current fiscal years (Hospital Outpatient II, Laboratory Specialty, PRO/FI/Carrier Denials and Adjustments, Post Cataract Home Health, Purchased Diagnostic Services).

Global Service/Fee Package Studies

Studies were performed on five high frequency/dollar surgical procedures to determine the feasibility of developing model packages of services that all carriers could follow when making payments. Generally, each study followed the same analytical process; literature search, BMAD data analysis, expert physician panel, and development of global service/payment package recommendations. Study findings have been used to further discussions on development of Part B

physician payment reform. For example, findings from these studies were used during negotiations with the American Medical Association in developing a national global fee package for surgical procedures.

Selected surgical procedures studied were:

Cataract – Based upon information obtained from previous studies of the cataract procedure, we were able to identify the typical operative procedures which are performed during a cataract operation. We next calculated the amount each carrier paid for a "package of services" identified to that provided during a cataract procedure. We found that there were some wide variations in the fee paid by carriers for this package of services which did not appear to be related to cost of practice variations, etc... Accordingly, recommendations were made by which these fee variations could be reduced should new overpriced procedures legislation be considered, involving this procedure.

CABG – A study of physicians' billings for this type of surgery revealed that some primary surgeons billed not only for the CABG surgery itself, but also on a fragmentation basis for other services related to the surgery such as hospital visits and interpretation of tests. To a lesser degree, it was additionally found that some assistant surgeons and anesthesiologists billed not only for their respective role in the surgery but also for certain intraoperative procedures such as wound closure and placement of monitoring lines.

TURP – Detailed procedure data for a sample of beneficiaries who received a TURP in 1986 was obtained and reviewed. These data showed all the procedures billed to the Medicare program for a period of 6 months before and after the procedure. Procedures which previously were not related to a TURP were first removed from the data. Next, the relative frequency of occurrence for all remaining procedures; the physician specialty doing the billing and the time period before and after the procedure was established. A urology physician panel was then convened to examine these data and to tell us what procedures are generally provided to a typical TURP patient. The panel was able to provide us with a package of services which are usually provided to a typical patient.

Hip Reconstruction – This was a very complex and intensive study. An analysis of payment data on 23 major surgeries for incorporation into 2 global fee packages was completed; 1 package for surgeries generally performed as initial procedures (first surgery) and a second package for secondary procedures (second surgery on same hip). The packages focused on the services provided by the primary surgeon, including related pre/intra/post-operative services. We found that post-operative care for hip reconstruction surgeries extends for a longer period of time than other types of surgeries, for example, a surgeon may follow a patient up to 270 days after surgery.

Pacemaker – This study established one global fee package for pacemaker surgeries. Our physician panel provided us with very useful information. For example, most patients who have pacemaker surgery have a history of cardiac problems; pacemakers are implanted in only 20 percent of patients as a "cure all" procedure. In addition, the primary care physician performs very few of the pre/post-operative services surrounding the surgical procedures.

Therefore, prior to establishing the global fee package of services, all factors (e.g., medical necessity procedures, specialist performing the surgery) were taken into consideration. Our recommendations, for the most part, were in line with the Bureau of Policy Development and the Physician Payment Review Commission global model of services.

Hospital Outpatient Study II

The second study of hospital outpatient services provided to beneficiaries was conducted because of findings in the first study,

which revealed a large number of not medically necessary services and many situations where available documentation could not validate that the services were provided. The purpose was to determine: 1) if hospitals were billing for inappropriate and/or noncovered services in four selected categories (Pharmacy, Clinic, Surgery, and "Other") not reviewed in the first study, and 2) the appropriateness of fiscal intermediary claim adjudications. It was based on services provided in calendar year 1988, and involved 10 fiscal intermediaries, 40 hospitals, and 1,400 claims, all selected statistically. Beneficiaries' medical records were reviewed by medical professionals, including board-certified physicians in appropriate specialties.

The national findings primarily revealed a large amount of Medicare dollars paid for services that were provided but medical documentation was still inadequate, i.e., the physician reviewers could not determine medical necessity. There was also an indication of not medically necessary services, but not to the extent found in the first study. Additionally, in the first study, 15 percent of the Medicare dollars projected as paid in error were for situations where documentation did not validate that the services were provided; in the second study, it was only 3 percent.

Laboratory Specialty

During FY 1989, a study was undertaken to determine if carriers are paying independent laboratories for only those services the laboratory is certified by Medicare to perform for Medicare beneficiaries and to determine if carriers are updating their computer payment systems accurately and timely. The study involved 13 carriers servicing 15 States and 94 independent laboratories' billings during the period July 1, 1988 through December 31, 1988. The study found that payments (over $1 million in calendar year 1988) were made to independent laboratories for services they were not certified to perform. As a result of this study, revised instructions were submitted to the carriers on how to collect for overpayments resulting from the performance of tests and/or procedures for which the independent laboratories were not certified to perform by Medicare.

Post Cataract Home Health Study

This study determined the need for a national coverage policy on the number of skilled home health visits after cataract surgery. The study identified utilization patterns (average number of visits per surgery) at the national level and for each of the Regional Home Health Intermediaries (RHHI) and costs associated with an average skilled home health visit in which payment was made.

This study required creation of new data files (merging of Part A and Part B) not previously analyzed for program policy. We concluded that RHHI interpretation of coverage policy was adequate but some retraining at two RHHIs (Blue Cross of Iowa and Wisconsin) would improve the integrity of the national program. As a result of our study, BPD did not propose any changes to national policy on the number of covered skilled home health visits. In addition, study findings were used by HCFA to undertake the retraining effort of the two RHHIs and all other Regional Home Health Intermediaries at a national training conference.

PRO/FI/Carrier Denials and Adjustments

This study responded to concerns about the transmission of Peer Review Organization (PRO) denial and adjustment decisions and whether contractors (fiscal intermediaries, carriers) were making adjustments in an accurate and timely manner. To determine the level of compliance with written instructions, the study tracked the process of a sample of PRO denial/adjustments through the PRO to the fiscal intermediary and carrier.

Findings included: national average number of days taken by PROs to process cases exceeding parameters established in HCFA

instructions by at least 50 days; two-thirds of sampled PROs were out of compliance for timeliness of processing cases; overall processing time of cases by FIs was well within parameters established in HCFA instructions and were adjudicated accurately; 5 percent of PRO denials/adjustments were not processed by FIs; potential carrier adjustments represented less than 2 percent of the total adjustments from the PRO review process (FI adjustments represented more than 98 percent); and, the average carrier denied amount per case was only $68.00 while the average FI denied amount per case was $1,037.00. Study findings were utilized to retrain contractors and revise program instructions.

Purchased Diagnostic Services

Section 4051 (b) of OBRA 87 directed the Secretary to review the payment levels for the professional (and technical) component of "purchased diagnostic services." OBRA 87 defined purchased diagnostic services as services that are commonly performed (but not necessarily) by independent suppliers and sold as services to physicians to who then interpret the results and bill Medicare for those services. OBRA 87 explicitly excludes clinical diagnostic tests from this category. Therefore, a study of the payment levels of the professional component of a group of three cardiac related diagnostic tests were undertaken. This study first established the values of these services relative to Electrocardiographic monitoring (EKGs) and then compared Medicare payment for these services to Medicare payment for EKGs. This study concluded that payments for the professional component of ambulatory cardiographic (Holter) monitoring and the professional component of one cardiac ultrasound service are excessive relative to EKGs.

The relative value of these services was established through the efforts of a panel of physicians. The factors the panel considered in establishing relative values were physician time, effort and skill required to interpret the results of the tests being reviewed. Medicare payment data was collected through a survey of all carriers.

Epoetin (EPO) coverage

HCFA expanded Medicare coverage to include EPO for Medicare beneficiaries with anemia and acute chronic renal failure.

Audio Response Unit Purchase and Installation

Medicare carriers purchased and installed Audio Response Unit to help handle the expected increase in incoming beneficiary telephone calls due to the Part B Catastrophic cap (mandatory $1,370 limit on beneficiary out-of-pocket expenses for Part B services).

Programmable Magnetic Tape Terminal (PMTT) Data Communications System

Medicare carriers implemented a more effective data transmission network to support the Agency's Medicare data traffic. Carriers converted from the old PMTT network to the new Network Data Mover (NDM) network. The NDM network has the advantage of computer-to-computer communication.

Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of 1988 (MCCA), Public Law 100-360, enacted July 1, 1988, made very extensive amendments to Title XVIII of the Social Security Act. As a major segment of this legislation, the Secretary was mandated to, "...establish no later than January 1, 1991, a point-of-sale (POS) electronic system for use by carriers and participating pharmacies in the submission of information regarding covered outpatient drugs dispensed to Medicare beneficiaries under this part." This system would be capable of real-time, on-line transaction

processing of prescription drug claims.

In addition to the requirements the law made on the system by which prescription drug claims would be paid, the MCCA revised the definition of a carrier to include any voluntary association corporation, partnership or other nongovernmental organization which the Secretary determines to be qualified to serve as specialized Medicare carriers in the processing of drug claims. The carriers to be responsible for the electronic system were referred to as Drug Bill Processors (DBP).

HCFA worked within a highly compressed deadline in an effort to have the program up and running on January 1, 1991. After the initial months of research, for which a task force was created, HCFA issued a nine page informational document outlining its thoughts to date on the implementation of DBPs. Subsequent to analysis of this November 1988 package, HCFA issued a Draft Request for Proposal (RFP) for the DBPs (May 1989). Within a restrictive timeframe, HCFA was then ready to issue the final RFP in July 1989. In early August, HCFA held a preproposal conference for approximately 500 of the interested potential offerors during which questions and answers were exchanged.

A total of four sets of amendments to the RFP were issued to all interested parties (approximately 900 interested parties were on the mailing list) between August 14 and October 10, 1989 at which point HCFA suspended the closing date for receipt of proposals due to the impending legislative repeal of the MCCA.

Demonstration Project in California and Colorado

The implementation phase of the uniform hospital cost reporting demonstration project began for cost reporting periods beginning on or after July 1, 1989. All participating hospitals in the states of California and Colorado are required to submit their Medicare cost report (Form HCFA-2552-89) and their demonstration cost report worksheets (Form HCFA-2552-DEMO) in a standardized electronic format. Under the electronic format, hospitals submit raw input data to their fiscal intermediaries on a diskette. The affected intermediary systems will accept that diskette, perform certain edit and desk review checks, and compute a cost report. In the past, when intermediaries received a cost report (calculated electronically by commercial vendor software) they had to re-enter all of the input data into their electronic system.

To ease the burden on hospitals, we developed and made available, free of charge, software which enables hospitals to submit the input data on a diskette to the intermediaries. While this software does not calculate a cost report, it allows hospitals to enter all the data needed to calculate the cost report and meet the electronic reporting requirements.

Electronic Cost Reporting

Effective with cost reporting periods beginning on or after October 1, 1989 hospitals in all states are required to file their cost reports electronically. HCFA developed the electronic reporting format for implementing this requirement in FY 1989. The development was accomplished as part of the demonstration project in California and Colorado.

Incentive Payments for Physicians

Section 4043 of OBRA 1987 provided for an additional payment of 5 percent for physician services rendered in rural health manpower shortage areas (HMSAs) effective January 1989. The payments, which are made on a quarterly basis, are intended to provide an incentive for physicians to serve in medically underserved areas. Medicare carriers disbursed a total of nearly $2 million in incentive payments for eligible physician services rendered during 1989.

Fee Schedules for Medical Equipment

During 1989, HCFA implemented the home medical equipment fee schedule re-

quired by Section 4062 of OBRA 1987. The fee schedule methodology replaced the previous reasonable charge payment methodology for medical equipment used in the home. Under the fee schedule methodology, payment for an item of equipment is generally the same throughout the State. Payment for oxygen is based on the amount of oxygen prescribed rather than the amount of oxygen actually consumed.

Medicare Approve Heart Transplant Facilities

Medicare covers heart transplantations when furnished by participating facilities that meet specific criteria, including patient selection criteria. Applications from facilities wishing to become Medicare approved heart transplant centers are reviewed by individual non-Federal internationally recognized experts in relevant fields related to cardiac transplantation.

These experts make individual recommendations which provide the basis for HCFA's decision to approve or disapprove a facility for Medicare payment of heart transplants.

During FY 1989, eight hospitals were approved to receive Medicare payment for heart transplants, bringing the total number of approved facilities to 31.

The eight hospitals were:

- Baptist Medical Center, Oklahoma City, Oklahoma
- Los Angeles Medical Center, Los Angeles, California
- University of Washington, Seattle, Washington
- The Carolinas Heart Institute, Charlotte, North Carolina
- Columbia-Presbyterian Medical Center, New York, New York
- Sharp Memorial Hospital, San Diego, California
- M.S. Hershey Medical Center, Hershey, Pennsylvania
- Hartford Hospital, Hartford, Connecticut

Chapter V

Research, Demonstrations and Evaluations

Introduction

For a substantial period of time, the costs of health care services have been outpacing the rate of inflation in the general economy. This means that not only has the absolute number of dollars spent on health care increased rapidly, but also the proportion of the Gross National Product related to health care has increased. This trend continues to be a matter of primary concern to HCFA as the leading financer of health care in the United States. Since the establishment of HCFA, the overall purpose of its research and demonstration (R&D) program has been to find ways to moderate or control this inflationary trend and to ensure that every dollar is used effectively in the service of HCFA beneficiaries.

HCFA's R&D activities provide knowledge to enable the Administrator, the Secretary, Congress and other interested parties to make informed and rational decisions regarding HCFA programs and policies.

HCFA's existing research, demonstration and evaluation activities include projects to test new reimbursement, coverage, eligibility and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to quality health care services and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing R&D activities. These projects result in knowledge about the basic structure, incentives, costs and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis, and develop innovative financing and delivery systems.

In addition to its intramural projects, HCFA spent almost $48 million for grants and contracts to conduct research, demonstration and evaluation projects during the fiscal year. Of this amount, $23.9 million went to the approximately 150 studies that continued into FY 1989 from previous years. An additional $24.1 million went to fund 215 new projects, including $8.3 million awarded to 181 hospitals under the Rural Health Care Transition Grant Program.

The seven program areas addressed were: Quality of Care; Physician and Ambulatory Care Payment Systems; Capitated Payment Systems; Hospital Payment; Program Efficiencies, Analyses and Refinements; Health Care Prevention and Access; and Subacute and Long-Term Care. More specific information on individual projects can be found in the Status Report: Research and Demonstrations in Health Care Financing Fiscal Year 1989 edition.

Quality of Care ($7.1 million)

There are many relevant issues within the quality of care area. HCFA has a continuing interest in quality issues as they relate to: (1) the impact of payment mechanisms, such as the prospective payment system or the ESRD composite rate, on quality of care; (2) the impact of severity of illness on health care outcomes; (3) the effectiveness of alternative medical interventions on the health of Medicare beneficiaries; and (4) access to and quality of services in subacute care settings, such as home health and skilled nursing care.

Program changes have the potential to impact on the quality of care provided to program beneficiaries. In order to assess the impact of such changes, as well as to ensure

continued access by program beneficiaries to quality care, it is essential that valid quality of care measures for different treatment settings be developed. Twenty-three studies from previous years continued into FY 1989. Among these were:

Strategies for Assessing and Assuring Quality of Care in the Medicare Program (National Academy of Sciences). This is a 2-year congressionally mandated study (P.L. 99-509) to design a strategy for assessing and insuring the quality of care in the Medicare program. Its main purpose is to develop, within a committee of experts, a recommended strategy for quality review and assurance for Medicare beneficiaries.

Impact of the Diagnosis-Related-Group Based Prospective Payment System on Quality of Care for Hospitalized Medicare Patients (The RAND Corporation). This study will evaluate the impact of the prospective payment system (PPS) on quality of care. The effectiveness of medical care treatment will be evaluated by relating quality scores to mortality, readmission rates, and other outcome variables.

Study of Home Health Care Quality and Cost Under Capitated and Fee-For-Service Payment Systems (Center for Health Policy Research). This project is designed to compare the quality and cost of home health care provided under capitated and noncapitated payment systems for two groups of Medicare beneficiaries: clients admitted to home health care following a hospitalization, and those who have not been in a hospital for at least 30 days prior to the initiation of home care.

Development of Methodologies for Technical Assessment and Quality Assurance Based on the Medicare Claims Data System (Dartmouth College). This ongoing project, which involves the collection and analysis of data on patients who underwent coronary angiography in a New England hospital from 1984 to 1986, will allow HCFA to pursue research methodologies that should be used in studies relating to effectiveness of medical and surgical interventions in the Medicare population and would help validate the utility of Medicare claims data in studies of this type.

Development of Outcome-Based Quality Measures for Home Health Services (Center for Health Policy Research). The purpose of this ongoing contract is to develop and test outcome-based measures or indicators of quality for Medicare home health services. The measures are to be reliable and valid for use in monitoring and comparing quality of home health care across agencies, recognizing possible confounding factors such as case mix.

Use of Medicaid Reimbursement Data in the Nursing Home Quality Assurance Process (Center for Health Systems Research and Analysis). This project assesses the feasibility of using Medicaid reimbursement data to target facilities and residents in the nursing home quality assurance survey process. These data appear to hold considerable promise in helping target facilities for more intensive review, identifying specific areas of deficient care, and identifying individual residents for more detailed review.

Medicaid Quality of Care Study (SysteMetrics Inc./McGraw Hill). This congressionally mandated study (P.L. 99-509) examines the appropriateness, necessity, and effectiveness of selected medical treatments and surgical procedures for Medicaid patients.

Using Case-Mix Systems to Measure Quality of Care (Brandeis University Research Center). This completed project involved two separate activities:

- Using the hospital medical illness severity grouping system (MEDISGRPS) data base to examine the system's ability to predict and explain 30-day and 60-day post-admission mortality.
- Examining the relationship between severity scores produced through the

computerized severity index (CSI) costs of hospital admissions and in-hospital deaths.

Outcome Measures for Assessment of Hospital Care (University of Minnesota Research Center). This ongoing project explores the usefulness of outcome measures other than mortality in assessing the effectiveness of hospital care.

Hospital, Market, and Peer Review Organization Factors Affecting Unnecessary Utilization and Quality of Care (Abt Associates, Inc.). This congressionally mandated study will examine the interrelationship among peer review organizations (PROs), the prospective payment system (PPS), and utilization and quality of care problems.

Interpreting Hospital Mortality Data: How Much Can Patient Severity and Quality of Care Explain? (The RAND Policy Research Center). This project examines the Medicare Mortality Predictor System (MMPS), with a goal of enhancing and refining its capabilities and usefulness.

- Investigate the statistical properties of and develop a theoretically defensible standard error estimator for the MPS rate estimator.
- Develop a Baysian estimator for hospital mortality rates.
- Further investigate the sample design used to estimate the MPS risk-adjustment equations.
- Estimate how much of the variance in hospital mortality rates is attributable to variation in severity versus variation in quality of care.

Evaluating Quality of Care for Hospitalized Patients (Brandeis University Research Center). Equation-based severity models will be developed using common clinical information abstracted from charts on hospitalization to predict adverse surgical outcomes such as readmission, common surgical complications (including unplanned return to surgery), and evidence of a post-surgery myocardial infection. This work will further HCFA's ability to compare the quality of surgical cases using outcomes more sensitive than mortality with adequate severity of illness adjustments.

Psychoactive Drug Use Among Nursing Home Elderly (University of Minnesota Research Center). This study will examine the extent of regular and "as needed" psychoactive drug use among nursing home elderly and the possibility of appropriate and inappropriate use of such drugs in terms of characteristics of nursing home residents and nursing homes.

Physician and Ambulatory Care Payment Systems ($7.1 million)

HCFA's physician and ambulatory payment research agenda is based on a commitment to better understand the underlying reasons for the rapid growth in Medicare spending for physician and outpatient services and to implement reforms to the current system. The research is intended to support proposals for reform of Medicare physician and ambulatory care payment policies and be responsive to the increasing interest on the part of Congress in developing more rational payment systems.

Thirty extramural studies in these areas continued into FY 1989 from previous years, including:

Geographic and Temporal Variations in Medicare Physician Expenditures (Center for Health Economics Research). This project will address a broad range of physician payment issues, including overpriced surgical and anesthesia fees, decomposition of Part B expenditures into price and quality components, effect of competition on price and quantity variation, variation in assignment rates and participation, and incentives provided by Medicare's at-risk payment rates.

Development of Physician Malpractice Index Reports (Metrica, Inc.). This

now-completed project sought to develop three types of indexes of physician malpractice insurance costs, i.e., fixed liability limits, actual premium expenditures by physicians, and constant risk. The latter index examines changes in the costs of sufficient malpractice insurance coverage to provide a constant minimum risk of loss of physician earnings or capital from malpractice awards. Empirical comparisons were developed using premium data of a major insurer and physician survey data from the American Medical Association during the period 1975-85.

Impact of Medicare Fee Freeze and Participation Agreements on Physicians (Center for Health Economics Research). This now-completed project studied how physicians have responded to the Medicare fee freeze and participation agreement established in the Deficit Reduction Act of 1984. The primary objective was to determine whether physicians increased the volume of services provided or the levels and mix of services during the period when their fees and Medicare reimbursements were frozen. Data from 1984 were used to complete a report for three potentially overpriced procedures: lens implants, coronary artery bypass grafts, and pacemaker implants. Econometric analyses of the participation agreement were performed using data from the 1984 Physicians Practice Costs and Income Survey. Special analyses of the impact of the hospital PPS on physicians and analyses of refinements in the way Medicare pays for physician services were also conducted.

A National Study of Resource-Based Relative Value Scales for Physician Services (Harvard School of Public Health). Phase I of this congressionally mandated study (P.L. 99-272, 99-509, and 100-203) developed a national resource-based relative value scale and presented results for physician services in 18 specialties. Resource-based relative values are hypothesized to be a function of physician work before, during, and after the service, specialty-specific relative practice costs, and specialty-specific relative opportunity costs. The Phase I study showed a large variation in resource requirements both within and among specialties. Phase II extends the study to 15 additional specialties and subspecialties and refines and revises the study methodology.

Toward Prospective Payment for Outpatient Department Surgical Services (The Urban Institute). This congressionally mandated project (P.L. 99-509) will provide information necessary to assist HCFA in designing a PPS for surgical procedures performed on a hospital outpatient basis.

Development of a Prospective Payment System for Hospital-Based Ambulatory Surgery (Brandeis University). This congressionally mandated project (P.L. 99-509) will provide information needed to assist in the development of a Medicare PPS for hospital outpatient surgery. This project will compare and evaluate the utility of several alternative patient classification systems in classifying outpatient cases by relative resource intensity.

Design and Evaluation of a Prospective Payment System for Ambulatory Care (Health Systems International). This congressionally mandated project (P.L. 99-509) will develop a patient classification system that can be used as the basis of payment for an outpatient PPS for Medicare. The payment system must be administratively feasible, implemented with Medicare claims data, and applicable as a basis of payment for facility costs and potentially for physician fees. Another task of the project is to develop a system that can be used for the prospective payment of ambulatory care services in both hospitals and ambulatory surgical centers.

Specialty Differentials Across Localities (The RAND Policy Research Center). This completed study had two objectives. The first was determining the presence and size of physician payment differentials between

specialists and nonspecialists across localities for a given set of procedures. This aspect also focused on the criteria used by carriers in defining specialists. The second objective involved an analysis of the effect of physician payment rate differentials across localities on the volume of services provided by physicians.

Determinants of Cost of Care: The Influence of Physician Style Versus Patient Characteristics (University of Minnesota Research Center). Significant variations in the cost of managing patients with the same diagnosis have been documented. This ongoing study will help determine what percent of variance in the cost of care is caused by physicians' unique practice patterns and what percent is caused by differences in patient population characteristics and disease severity.

In FY 1989, HCFA also implemented 28 new physician and ambulatory care payment studies. Among them are:

Medicare Cataract Surgery Alternate Payment Demonstration (Abt Associates, Inc.). The objective of the task is to assist HCFA in the design, implementation, and evaluation of a demonstration to assess the feasibility of an all-inclusive negotiated price concept for cataract surgery. The negotiated price, covering physician, facility, and intraocular lens costs for the procedure, would be tested at three sites, but participation by providers and beneficiaries at each site would be strictly voluntary.

Medicare Participating Heart Bypass Center Demonstration (Lewin/ICF). The task objective is to assist HCFA in implementing and evaluating a 3-year demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for CABG surgery while maintaining high-quality care.

Controlling Physician Expenditures in a Hospital Setting: Medical Staff Expenditure Targets (The Urban Institute). The aim of this project is to study expenditure growth targets for hospital medical staffs as an alternative physician payment method that would provide incentives for physicians to contain costs of services delivered in a hospital setting. The primary study objective is to identify the distributional effects of a prospective per-case method of payment for physician services in a hospital setting (that is, both inpatient services and outpatient surgery). Results could provide useful information about how a medical staff payment model might be implemented within a physician payment system based on volume performance standards.

Physician Preferred Provider Organization Demonstration Sites (Family Health Plan; CAPP CARE, Inc.; HealthLink, Inc ; CareMark, Inc.; Blue Cross and Blue Shield of Arizona). Five preferred provider organizations (PPOs) are participating in this Medicare physician PPO pilot demonstration. These demonstrations will enable HCFA to assess the operational feasibility of the Medicare PPO concept through an analysis of biased selection, beneficiary choice, and the impact of the demonstration on Medicare costs and utilization. Since each site is a unique model, the evaluation will also examine how the sites' features contribute to their individual success.

Medical Visit Coding (The RAND Policy Research Center). The primary objective of this study is to describe the variation in intensity of medical visits and to evaluate the impact of alternative ways of coding medical visits.

Concurrent Care During Surgical Admissions (The RAND Policy Research Center). The three major objectives of this project are to: provide descriptive statistics documenting

variations in the number of visits and consultations by non-attending physicians for Medicare surgical admissions; examine the effect of concurrent conditions on the number of visits and consultations by non-attending physicians; and identify and determine the frequency of patterns of concurrent care that may be clinically inappropriate.

Global Fees for Surgery (Brandeis University Research Center). Most surgeons and carriers in a given area share a common definition of the global fee. Wide variations between areas and in physician billings have been observed, however, for related diagnostic and surgical services. Concern exists that some surgeons may bill extra for related services to offset any perceived revenue losses caused by a Medicare fee schedule based on the resource-based relative value scale. This study will involve documenting current billing patterns by surgeons for extra services and evaluating potential unbundling that might occur if a uniform national global fee definition replaces current billing practices.

Billing Patterns for Critical-Care Physician Services (Project HOPE Research Center). The objective of this project is to evaluate the potential for bundling payments for critical-care physician services under Medicare into more inclusive payment packages. Physician critical-care services are provided in coronary care, intensive care or other emergency care units of hospitals. An analysis of physician billing patterns for critical-care services and an examination of the extent of variation in utilization and costs will be performed. These analyses will be used to evaluate the potential for bundling payments for these services.

Capitated Payment Systems ($2.1 million)

Prior R&D activities involving health maintenance organizations determined that alternative coordinated/managed care delivery systems and alternative risk reimbursement mechanisms are cost-effective and offer Medicare beneficiaries the opportunity for improved benefits over the existing fee-for-service system. Forty-one studies testing alternative payment methods, including eight new studies, were underway in FY 1989 in such areas as outpatient services payment, End Stage Renal Disease (ESRD) payment, the Medicare Insured Group (MIG) demonstrations, and State programs for long-term care. Projects tend not to be limited to one segment of the Medicare population or to one aspect of the health care delivery and financing system. Within this area, researchers attempt to identify, test and evaluate cost-effective alternative delivery and/or financing systems that affect multiple segments of the program. Therefore, the agency continued to examine coordinated/managed care delivery systems involving capitated payments for various types of services and those projects that tried to refine or test alternatives to the current methods and bases for payments to capitated systems. HCFA also continued evaluations of a series of HMO demonstrations and an evaluation of the TEFRA HMO and CMP programs.

Among the prior years' projects that continued into FY 1989 were:

Tax Equity and Fiscal Responsibility Act of 1982 Health Maintenance Organization and Competitive Medical Plan Program Evaluation (Mathematica Policy Research, Inc.). The evaluation is designed to examine the impact of the program on HCFA, health care providers, and Medicare beneficiaries.

Social Health Maintenance Organization Project for Long-Term Care (Elderplan, Inc.; Senior Plus; Medicare Plus II; SCAN Health

Plan). This congressionally mandated project (P.L. 98-369 and 100-203) developed and is currently implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Medicare Insured Groups (MIGs). Under the MIG concept, retiree health benefits, both private and Medicare, are centrally administered under the auspices of a single entity, with Medicare providing funding through a capitated rate. A potential MIG demonstration by the Amalgamated Life Insurance Company is still in the planning stage, as is a new MIG demonstration proposed by the Southern California Edison Company.

Determination of Health Maintenance Organization Capitation Rates for Medicare Beneficiaries (Kaiser Foundation Research Institute). This project is investigating the issue of biased selection into HMOs and the problem of developing a risk-adjustment methodology for HMO payments by using both internal Kaiser data and data from the Medicare Statistical System.

Clinical Refinement of Diagnostic Cost Group Model (Brandeis University Research Center). The objective of this project is to develop conceptual clinical models identifying patterns of hospitalization data that can be used to categorize individuals whose continuing needs for health care services will result in higher future costs. A new diagnostic cost group classification system will be produced and payment rates to HMOs determined. This project is intended to produce improved formulas for determining payments to HMOs.

Capitated Community Nursing Organizations (Project HOPE Research Center). This congressionally mandated study (P.L. 100-203) will assist HCFA in designing a project to provide Medicare payment on a prepaid capitated basis to community nursing organizations.

Major new initiatives during the year included:

Medicare Payments to Health Maintenance Organizations: Beyond a Local Fee-For-Service Methodology (The Urban Institute). This project will investigate whether favorable selection by HMOs in areas of high HMO penetration affects the health status and cost of those Medicare beneficiaries remaining in the fee-for-service sector. If it does, capitation rates set for HMO enrollees may be too high. If such an effect is found, alternatives to current methods for setting capitation rates in high-penetration areas will be explored.

Alternatives to Fee-For-Service as a Base for Health Maintenance Organization Premium Setting (University of Minnesota Research Center). Currently, HMOs that enroll Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act risk contracts are reimbursed 95 percent of eligible costs the enrollees would have incurred if they had remained in the fee-for-service (FFS) sector. This approach of linking HMO payments to FFS costs has been criticized by some on both technical and conceptual grounds. The purpose of this project, therefore, is to develop and analyze alternative methods of reimbursing HMOs for their care of beneficiaries.

Impacts of the Working Aged on Medicare Expenditure Rates (Brandeis University Research Center). Because Medicare is the secondary payer for aged persons who are covered by employer medical insurance, HCFA does not get complete data on beneficiaries' medical care use and costs. As a result, since the health care costs for the working aged are not fully reflected in Medicare's capitation payments, HMOs believe that the capitation rates for all enrollees are unfairly lowered. This project will

attempt to determine the legitimacy and magnitude of the problem and any corrective measures in the rate setting process that may be necessary.

Examination of Alternatives to the Adjusted Average Per Capita Cost Geographic Factor (Brandeis University Research Center). The geographic adjuster of the adjusted average per capita cost (AAPCC) is currently a moving 5-year average of the ratio of county costs to national costs. The most recent data entering the 5-year average are 3 years old and the oldest data are 8 years old. Thus, this approach may not accurately reflect a county's current status. In addition, it can result in large random year-to-year fluctuations in local AAPCCs, as well as dampen any trends toward increasing or decreasing relative costs in an area. More sophisticated time series methods, which may give a more accurate estimate of counties' current costs relative to national costs, and Baysian methods of reducing random fluctuations, by combining county data with data from a larger area, will be investigated.

Hospital Payment ($10.8 million)

HCFA continued to investigate issues related to the refinement and expansion of the prospective payment system (PPS) during FY 1989, the sixth year of prospective payment. Twenty-seven extramural hospital payment studies begun in prior years continued into FY 1989. These studies, which focus on a range of hospital payment issues, include:

Prospective Capital Payment: Refinements and Impacts (Center for Health Economics Research). Congress imposed a moratorium on prospective capital payment as a result of concerns about why some hospitals were projected to be big "losers" under the proposed FY 1988 prospective Medicare capital payment system. This project examines the proposed policy and develops and evaluates potential refinements.

Medical Assistance Facility Demonstration Project (Montana Hospital Research and Education Foundation). The Foundation will be conducting a demonstration of the utility and desirability of medical assistance facilities (MAFs) as a new type of frontier health care facility. MAFs, which provide low-intensity acute care services to short-term inpatients, are intended to maintain access to basic acute and emergency care services.

Natural History of Post-Acute Care for Medicare Patients (University of Minnesota). This is a study of the courses and outcomes of post-acute care. It has two major components: analysis of Medicare data to assess differences in patterns of care across the country and to determine the extent of substitution where various forms of post-acute care services are more or less available; and detailed examination of clinical cases from the most common diagnosis-related groupings receiving post-acute care in a few selected locations.

A Diagnosis-Related-Group-Based Case-Mix Analysis of Oncology Care in Comprehensive Cancer Centers (Brandeis University). The short-term goal of this project is to improve the ability of the current diagnosis-related group (DRG) system to account for variability within DRGs containing cancer diagnoses. The long-term goal is to develop a classification methodology that can discriminate among admissions with different resource requirements for three types of cancer: colon, breast, and lung.

Interaction Between Medicare Payments and Nursing Shortages (Project HOPE Research Center). This study examined the interaction taking place between PPS and the nursing shortage being reported by hospitals in many areas of the country. The study concluded that implementation of PPS and increases in case-mix complexity contributed to, but did not fully explain, increases in demand for nurses by hospitals from 1981 to 1985.

Analysis of Case-Mix Growth Among Hospitals. Eleven new extramural hospital payment research studies were awarded including:

Rural Health Transition Grant Evaluation (Mathematica Policy Research, Inc.). Under this study, the contractor will perform both pre-award and post-award functions that include: monitoring a sample of grantees to determine that grants are expended appropriately; conducting an evaluation of the projects funded; and reporting to HCFA the perceived needs of rural hospitals.

Hospital Closures, Financial Status, and Access to Care: A Rural and Urban Analysis (Georgetown University). This project addresses two questions: Why do hospitals close? and How do closures affect access? A hospital-level analysis will be done to examine factors that cause hospitals to close. Closed hospitals will be compared with similar hospitals that remain open with respect to admissions, costs, Medicare and non-Medicare revenues, Medicare patients, and patterns of care. Separate analysis will be conducted for rural and urban areas to identify factors unique to each type of community. A patient-level analysis will compare patients of closed and open hospitals along the following dimensions: diagnostic mix, severity of illness, and patterns of care. In addition, these two groups of patients will be compared to determine whether closure has an adverse effect on access to or outcome of care.

Access to Care in Rural and Inner City America (Center for Health Economics Research). This project is designed to examine changes in utilization trends for 1985 through 1989 in the catchment areas of 18 hospitals that closed inpatient services during 1986-87. The researchers expect to determine whether closures significantly limit access to care for beneficiaries.

Diagnosis-Related Group Outlier Payment Effect on Quality of Care (The RAND Policy Research Center). There are concerns that Medicare reimbursement under the diagnosis-related-group system may induce inappropriate levels of care by paying too much for the outlying patient and too little for the expensive patient who is not an outlier. This research is designed to examine two specific questions: Do outlier payments have any effect on levels and quality of care? and What factors are responsible for extremely expensive or long hospital stays? This study will use detailed clinical data on 15,000 patients to determine whether outlier payments have any effects on levels and quality of care and what factors are responsible for extremely expensive or long hospital stays.

Health Care for Poor and Rural Hospital Patients (The RAND Policy Research Center). This project will be used to analyze how rural and inner city residents differ from other hospitalized Medicare patients with respect to quality of care, as measured by processes and outcomes adjusted for sickness at admission.

Program Efficiencies, Analysis, and Refinements ($8 million)

Congress has prompted major changes in the past few years to improve the effectiveness and efficiency of the Medicare program. Research on and evaluation of these changes, as well as on factors influencing program performance, provide the information on health care expenditures and utilization patterns of Medicare beneficiaries necessary to achieve more cost-effective program operations.

Essential to this effort is the improvement of existing Medicare data bases. Several aspects of program performance also have been studied to improve understanding of them. Factors influencing utilization of particular types of services and the characteristics of certain categories of beneficiaries continue to be examined.

Thirty-seven projects from previous years continued into FY 1989, including:

Medicaid Tape-to-Tape: Research Data and Analysis (SysteMetrics, Inc.). This project continues the development and implementation of a Medicaid person-level data set from the five State Medicaid Management Information Systems in California, Georgia, Michigan, New York, and Tennessee. This project will provide a continuum of 9 years of uniform Medicaid data for the conduct of analysis of program management, evaluation of policy alternatives, and feedback to States in the area of Medicaid financing.

Evaluation of Medicare Expenditures for Durable Medical Equipment (Center for Health Economics Research). This research is intended to provide HCFA with information on whether Medicare is paying fair market rates for durable medical equipment; that is, whether Medicare reimbursements are above competitive prices.

Predictors of Cost and Success in Kidney and Heart Transplantation (Battelle Human Affairs Research Centers). This project examines the patient and organizational characteristics that determine successful kidney and heart transplantation outcomes. Using multivariate life-table methods, data from the Medicare program will be combined with information from surveys of transplant facilities to construct a model of transplant facility effectiveness.

International Comparative Data and Analyses on Health Care Financing and Delivery Systems (The Organization for Economic Cooperation and Development). The focus of this project is on developing, updating, and refining an internationally comparable data base on health care spending patterns, prices, utilization, and delivery system characteristics. Data developed under this contract provide the best possible contemporary basis for performing cross-national comparisons of health systems.

Small Business Innovation

Under the Small Business Innovative Research (SBIR) program (P.L. 97-219), HCFA continued its funding of several low-cost studies. Among these were:

Diagnosis-Related-Group-Specific Resource Management Software for Hospitals (John Rafferty and Associates). The objective of the project is to create a software package (which is currently under development) for predicting and evaluating hospital resource use and needs on a DRG-group basis.

Acquired Immunodeficiency Syndrome Comprehensive Monitoring System Pilot Project (Research Consultants). There are four objectives in this project, which is currently in the product development stage:

- To identify the service components and the source of payment for AIDS and AIDS-related complex patients who receive care in alternative settings and develop a software package reflecting these data for use by providers.
- To identify the services that are requested but are not available in alternative-care programs.
- To develop standard protocols for collecting units of service use and cost data in AIDS alternative-care settings.
- To develop a microcomputer-based system for monitoring and managing AIDS patients' costs in alternative settings.

In FY 1989, HCFA also funded 26 new studies. Among these were:

New York Welfare Reform: Child Assistance Program (State of New York). This demonstration has waivers from HCFA, the Family Support Administration, and the Department of Agriculture (food stamps). In the experimental group, as an incentive to employment and to filing court orders for child support, recipients of Aid to Families with Dependent Children (AFDC) who go to

work and file for child support have more of their earnings and the collected child support disregarded in the calculation of their income for AFDC eligibility. Since this is expected to keep recipients eligible for welfare for a somewhat longer period during employment, those who work their way off welfare receive only a 4-month Medicaid extension. The control group receives the current law's 4-, 9-, or 15-month Medicaid extensions, and lower income families receive the longer extensions.

Evaluation of the Alcoholism Service Demonstration (MayaTech Corp.). Under this project, the contractor will produce a report that addresses the effectiveness of the demonstration that expanded Medicare and/or Medicaid coverage to freestanding alcoholism treatment centers. The contractor will examine the impact of the demonstration on the use and cost of services.

Utilization Management Techniques for Physicians' Services and Non-Physician Ambulatory Services (Center for Health Policy Studies). This is a project to prepare a practical guidebook that identifies and assesses the performance of private sector programs to monitor and reduce excess utilization of physician and ambulatory services. The focus will be on programs that are particularly suited to Medicare and its utilization experience.

Development of New Automatic Interactions Detection Software (Austin Data Management Associates). This project will develop a new computer software package to perform automatic interactions detection (AID). AID was used in the development of the Medicare hospital payment system based on diagnosis-related groups. AID is being used in the development of case-mix classification systems. The proposed product will vastly improve the ability of a user who is not a programmer to operate AID.

Development of a Tool for Assessing Hospital Bed Needs in Rural Communities (Laguna Research Associates). This project will develop an empirical model of hospital utilization that can be used by rural communities to assess bed needs in a community and, thereby, assist in their long-range planning.

Dispensing Physicians as Participating Pharmacists (Brandeis University Research Center). The purpose of this project is to examine the role of physicians in the dispensing of prescription drugs in the United States, with a particular emphasis on the elderly population. Physician dispensing will be explored by focusing the analysis on the drug repackaging industry that provides drug products and related services to most physicians who engage in dispensing.

An Analysis of Medicare Expenditures for Ambulance Services (Project HOPE Research Center). This project is designed to analyze spending for ambulance services under Medicare. Both the nature and composition of spending for ambulance services and the amount of ambulance services used by beneficiaries with different characteristics will be examined. An attempt will be made to measure the difference between Medicare payments for basic ambulance transportation and the payments that would have been made had other transportation alternatives been used.

Study of Inappropriate Use of Medications by Medicare Beneficiaries (University of Minnesota Research Center). Medications prescribed by physicians are sometimes ineffective or even harmful. For both physiologic and social reasons, the elderly are susceptible and vulnerable to the consequences of taking unnecessary or deleterious medication more than any other age group. Before developing a policy to address this issue, it is important to have reliable estimates of the prevalence of inappropriate medication use among the elderly and to understand why

it occurs. The purpose of this study is to review and summarize the existing literature to determine the magnitude of the problem by using billing claims and eligibility data.

Health Care Prevention and Access ($3.4 million)

Current coverage rules governing Medicare do not allow reimbursement for most preventive services. HCFA, however, continues, through its research, to maintain an interest in the potential beneficial effects of particular preventive medical services and beneficiary access to services.

Eleven extramural projects from previous years continued into FY 1989, including:

Study of Medicare Coverage of Influenza Vaccine Demonstration and Evaluation (Abt Associates, Inc.). This contractor is providing assistance to those sites testing the cost-effective of furnishing an influenza vaccination as a Medicare-covered benefit, as mandated by P.L. 100-203. Abt is also ensuring that appropriate data collection activities take place so that the evaluation contractor will be able to conduct the cost-effective analysis.

Evaluation of the Omnibus Budget Reconciliation Act of 1987 Medicare Payment for Therapeutic Shoes for Individuals with Severe Diabetic Foot Disease Demonstration (Mathematica Poly Research, Inc.). The demonstration tests the cost effectiveness of furnishing therapeutic shoes to Medicare beneficiaries with severe diabetic foot disease. The demonstration utilizes a randomized design with equal numbers of treatment group and control group beneficiaries.

Health Care Services for Children Under Medicaid (The Johns Hopkins University). This is a comparative study of health care services for children by using billing claims and eligibility data.

Prevention Studies

Section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 requires the Secretary to conduct, evaluate, and report on demonstration programs designed to reduce disability and dependency through the provision of preventive health services to beneficiaries. In partial response to this mandate, the following studies were initiated:

Cost Utility of Medicare Reimbursement for Preventive Services in a Health Maintenance Organization (University of Washington School of Public Health and Community Medicine). This project is implementing a randomized design to assess the cost savings and changes in health-related quality of life associated with providing a preventive-service package (annual health risk assessment, individual health promotion, and group counseling) for Medicare beneficiaries enrolled in Group Health Cooperative of Puget Sound.

Preventive Health Services for Medicare Beneficiaries: Demonstration and Evaluation (The Johns Hopkins University). This demonstration is providing preventive services to a representative population of beneficiaries residing in the eastern half of Baltimore City. The University will also conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Preventive Health Services for Medicare Beneficiaries (University of Pittsburgh). This demonstration is providing preventive services to beneficiaries residing in rural counties in western Pennsylvania. The University will also conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Preventive Health Services for Medicare Beneficiaries, San Diego Demonstration Project (San Diego State University Foundation). Approximately 1,800 Medicare patients currently enrolled in the Secure Horizons HMO have been randomly assigned to either a treatment or a control group. The

San Diego School of Public Health will conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

University of California, Los Angeles, Medicare Prevention Demonstration (University of California). Approximately 2,100 beneficiaries who are current patients of the University of California, Los Angeles, university-based clinic have been randomly assigned to either a treatment or a control group, with a subsequent evaluation to assess the cost effectiveness of providing preventive services.

Five new projects were funded during this fiscal year, among which were:

Cost-Effectiveness Study of Medicare Coverage of Influenza Vaccine (Abt Associates, Inc.). This congressionally mandated study (P.L. 100-203) will evaluate the cost effectiveness of immunizing Medicare Part B beneficiaries against influenza. The evaluation will address: total vaccination expenditures per averted hospitalization and/or death, and comparison of the benefits (expenditures saved) of Medicare influenza vaccine coverage versus the costs (expenditures created).

Analysis of the Health Care Financing System (Lewin/ICF). This project will address the Presidential Directive from the AIDS Commission to conduct an analysis of the health care financing system. The study focuses on access to adequate health care by the American public under the current system of health care financing. Alternatives for the uninsured and the underinsured will be developed; the fiscal impacts of these strategies, as well as the utility of the strategies for policymaking will be analyzed.

Subacute and Long-Term Care ($9.5 million)

HCFA continues to investigate and has expanded its examination of issues relating to subacute and long-term care. Studies focus primarily on the areas of: alternative payment and delivery, long-term care populations, and case-management studies. A total of 32 studies initiated in previous years continued into FY 1989, including:

Home Health Agency Prospective Payment Demonstration (Abt Associates, Inc.). The purpose of this congressionally mandated project (P.L. 100-203) is to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under Medicare. The demonstration will enable HCFA to evaluate the effects of various methods of prospective payment on health care expenditures, quality of home health care, and home health agency operations.

Community Care for Alzheimer's and Related Diseases (The Urban Institute). The Urban Institute will analyze data from the National Long-Term Care Channeling Demonstration (1982-84) to determine the range of services, sources, and costs of care used by community residents with cognitive impairment. The Institute will also determine the risks of their entering nursing homes as a function ofphysical and mental health status, and the types and amounts of care received in the community. This study will provide baseline information for the Medicare Alzheimer's Disease Demonstration that is mandated by P.L. 99-509.

Evaluation Design for Medicare Alzheimer's Disease Demonstration (Mathematica Policy Research, Inc.). The contractor is responsible for assisting HCFA in designing and implementing a demonstration, as mandated by P.L. 99-509, to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders.

New Jersey Respite Care Pilot Project (New Jersey Department of Human Services). This project was established to help individuals care for elderly and disabled family members who at risk of institutionalization by providing services and support needed by both care recipients and caregivers. The purpose of the study is to determine the extent to which the provision of respite care services will delay or avert institutional placement and enhance and sustain the role of the family in providing long-term care services. This project began in July 2, 1988; all of New Jersey's 21 counties are participating in the program.

Efficacy of Nursing Home Preadmission Screening (Brown University). The purpose of this project is to evaluate a nursing home preadmission screening methodology developed to identify those persons who would be institutionalized in community-based services were not available. The project is analyzed the extent to which the screen accurately predicts the need for a nursing home level of care or an equivalent level of community care.

Research on Acquired Immunodeficiency Syndrome Costs and Utilization Experience in New York and California Medicaid Programs (SysteMetrics, Inc.). The purpose of this project is to:

- Use epidemiological techniques to produce incidence analysis of AIDS over a 4 1/2 year (10/82-3/87) period. Study the eligibility patterns of AIDS patients in Medicaid.
- Develop a disease-staging algorithm for AIDS Medicaid patients.
- Provide a utilization and cost analysis of the population. The first year of this study has been devoted to efforts concentrated on methodological activities such as: developing common definitions for key variables; constructing data files for research; and refining the disease-staging algorithm for AIDS.

Capitation Reimbursement for Frail Elderly (Brandeis University Research Center). This project is examining data on Medicaid nursing home certifiable beneficiaries as a means to analyze and refine the capitated reimbursement methodology being implemented in the Congressionally mandated demonstration of a program for all-inclusive care for the elderly.

Financial Impact to Beneficiaries of Nursing Home Care (Brandeis University Research Center). The project is using the Urban Institute's Transfer Income Model (TRIM)-2 for State estimates and the Connecticut Nursing Home Inventory data base to calculate nursing home use and payments. In addition, the 1985 National Nursing Home Survey is used to analyze several dimensions of nursing home use. From the collected data, estimates will also be made for the nursing home patients' spend-down provision.

In addition, 11 new studies were initiated during this fiscal year. The new studies include:

Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration (Institute for Health and Aging). The Medicare Alzheimer's Disease Demonstration, authorized by Congress under P.L. 99-509, will determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services to beneficiaries who have dementia. Two models of care are being studied under this project. Both provide case management, homemaker/personal care services, adult day care, and education and counseling for family caregivers. Case management activities include assessment, care planning, service arrangement, and patient monitoring. The two models vary by their monthly expenditure caps and the intensity of their case management. Eight sites are participating in this demonstration.

Long-Term Care Studies (Health and Sciences Research Incorporated). This project will conduct research related to the delivery and financing of long-term care

services for Medicare beneficiaries. The project will focus on financial impacts on beneficiaries and their families when long-term care services are required, beneficiary characteristics that affect utilization of long-term care services, and how the provision of long-term care services may reduce expenditures for acute-care services.

The Multi-State Nursing Home Case-Mix and Quality Demonstration (State Medicaid Agencies). This project builds on past and current initiatives with case-mix payment and quality assurance. The 4-year demonstration will design, implement, and evaluate a combined Medicare and Medicaid system in Kansas, Maine, Mississippi, and South Dakota. The purpose is to test a resident information system with variables for classifying residents into homogenous resource utilization groups for equitable payment and for quality monitoring of outcomes adjusted for case mix.

Evaluation of the Arizona Health Care Cost-Containment System (Laguna Research Associates). This project will evaluate the continuing operation of the Arizona Health Care Cost-Containment System (AHCCCS), with particular emphasis on the implementation and operation of the Arizona Long-Term Care System, a new component of AHCCCS.

Goals and Strategies for Financing Long-Term Care (University of Minnesota Research Center). This study will use concepts drawn from a number of disciplines -economics, decision sciences, policy analysis, sociology, and demography - to develop statements of possible objectives for long-term care insurance. Defining objectives will include an analysis of benefits and costs from potential changes in financing and an analysis of expected behavioral changes in response to changes in financing.

Analysis of Cost, Patient Characteristics, Access, and Service Use in Urban/Rural Home Health Agencies (University of Minnesota Research Center). The purpose of this project is to study urban and rural differences in home health agency costs, patient characteristics, access to care, and service utilization patterns.

Activities of Daily Living Measurements as Determinants of Eligibility (Brandeis University Research Center). This study will examine issues associated with defining and measuring activities of daily living (ADLs) for use as eligibility Criteria for Medicare services. A cost analysis will be performed and other issues associated with using ADL scores as eligibility criteria will be discussed.

Rural Health Care Transition Grants Program

Under the Rural Health Care Transition Grants Program mandated by Public Law 100-203, HCFA awarded 184 grants to 181 small rural hospitals in FY 1989.

This program is designed to provide assistance to small rural hospitals and their communities in planning and implementing projects to strengthen the capability of these hospitals to provide high quality care to Medicare beneficiaries. Under the program, eligible rural hospitals could request up to $50,000 per year for up to 2 years to support projects intended to adjust for one or more of the following factors:

- Changes in clinical practice patterns
- Changes in service populations.
- Declining demand for acute care inpatient hospital capacity.
- Declining ability to provide appropriate staffing for inpatient hospital services.
- Increasing demand for ambulatory and emergency services.
- Increasing demand for appropriate integration of community health services.
- The need for adequate access to emergency care and inpatient care in areas in which a significant number of underutilized hospital beds are being eliminated.

Hospitals qualified for this program if they were non-Federal, not-for-profit, short-term

general acute care hospitals, located in rural areas (i.e., currently being paid as rural hospitals under Medicare PPS) and had fewer than 100 available beds (as defined on the Medicare cost report).

In designing the grant program and solicitation materials, HCFA consulted with the Public Health Service's Office of Rural Health Policy, the American Hospital Association, the National Rural Health Association, the National Governors' Association, and the National Association of Counties.

HCFA received 704 applications in response to solicitation announcements and application materials that were mailed to each rural hospital. Four hundred and seventy-two applications were submitted by hospitals applying as individual facilities; 232 were submitted by hospitals applying as part of a consortium (a total of 58 consortia applied). Applications were received from each State, except Massachusetts, in which there were eligible rural hospitals.

Each application was reviewed for technical merit by a panel of experts. The panel's recommendations were taken into consideration in determining the projects to be awarded under the approximately $8.3 million appropriated by Congress in FY 1989 for first year funding. Of the 184 awards, 145 were to hospitals applying as individual facilities and 39 were to hospitals applying as part of a consortia (11 consortia). Each State with an eligible hospital received at least one award.

Reports to Congress

In FY 1989, HCFA's Office of Research and Demonstrations submitted nine reports to Congress on various mandated studies and activities.

- *Study and Recommendations to Congress on Ways to Refine the Adjusted Average Per Capita Cost and the Adjusted Community Rate* (P.L. 99-509, Sec. 1913)
- *Review of the Impact of the Reduction of the Composite Rate for Renal Dialysis on Access and Quality of Care* (P.L. 99-509, Sec. 9335)
- *1986 Annual PPS Impact Report* (P.L. 98-21, Sec. 603)
- *1986 Annual Report on Quality of Post-Hospital Care* (P.L. 99-509, Sec. 9305)
- *Home Health Services (Alternative Reimbursement Methodologies)* (P.L. 97-414, Sec. 6)
- *DRG Refinement: Outliers, Severity of Illness and Intensity of Care* (P.L. 99-509, Sec. 9305)
- *Expansion of Swing Bed Program* (P.L. 100-203, Sec. 4005)
- *Utilization of Selected Medical Treatments and Surgical Procedures Provided to Medicaid Recipients* (P.L. 99-509, Sec. 9432)
- *Preventive Health Services Under Medicare* (P.L. 99-272, Sec. 9314)

Chapter VI

Promoting Improvements in HCFA

Introduction

HCFA management accomplishments during the year included the adoption of the Project to Redesign Information Systems Management, a computer system to organize its data, improve accuracy, accessibility, and timeliness of information. HCFA instituted measures to promote wellness and fitness awareness program utilization among agency employees. The agency also increased its efforts to attract highly qualified job applicants.

Administration of Contracts and Grants

HCFA's Office of Acquisition and Grants is responsible for planning, awarding, administering, and interpreting policy for contracts and grants. This function includes all major HCFA administrative and Peer Review Organization (PRO) contacts, small purchases, cooperative agreements and grants. These activities require daily interactions with the Department of HHS, state, local, and private officials. A summary of the major procurement activities follows:

- Processed 374 actions related to new or modified general contracts valued at $83.8 million.
- Approximately 500 PRO contracts/modifications were awarded in the amount of $588 million.
- Administered 437 general contracts valued at $319.7 million.
- A total of 337 new grants, cooperative agreements, waiver-only grants, modifications were awarded valued at $1.5 billion.
- A total of 2,090 purchase order actions/ modifications were awarded valued at $13.3 million.
- HCFA documented $2.9 million in savings in general contract negotiations, $251.510 million in grant savings and $116.9 million in PRO contract savings.
- Approximately 5,100 requests for proposal packages were issued to prospective offerors.
- Approximately 4100 grant application packages were issued to prospective grantees.
- Approximately 1,500 invoices/vouchers were reviewed and certified for payment to contractors. Approximately 2,600 invoices/vouchers were reviewed and certified for payment to PRO contact.

Project to Redesign Information Systems Management (PRISM)

HCFA has undertaken PRISM to meet its current information needs and to develop the data processing capacity needed to implement the Administration's health care initiatives. Through PRISM, the Agency is moving from an independent applications systems design and operation to an integrated data base management environment. This environment will permit the Agency to organize its data, and improve the accuracy, accessibility, and timeliness of information. Both central and regional office personnel are realizing the advantages of: using personal computers; improved communications with HCFA's agents through the value added network (VAN); and improved access to data stored at the HCFA Data Center (HDC).

PRISM activities provided support to HCFA'S programs through improved access to data, electronic data communications, and enhanced data processing facilities. Specifically, it supported the accomplishment of the following Agency functions:

Common Working File—HCFA increased the automation of beneficiary selection process. The Central office conducted a prototype of the development of the Part B Medicare Annual Data (BMAD) files from the Texas and Maryland host sites. HI/SMI and common working file software changes implemented the provisions for the Part A portion of Catastrophic Health Insurance.

Data Administration—HCFA conducted a Data Users Conference to discuss uses and limitations of HCFA data with other government and non-government organizations and the public.

Software Development—The Agency has provided direct access to authorized users to Medicare beneficiary information, HMO data, Inpatient Hospital Cost Report data, physician payment data, longitudinal Medicare utilization data, contractor budget and cash management data, and provide certification data.

HCFA Data Center—An upgrade to a 3090-500E processor became operational on November 14, 1988. Network Data Mover provides CPU to CPU communications connections to the HDC for Part A claims data.

Training—The Agency developed prototype curriculum based on interviews with managers, program analysts, and accountants. Additionally, the agency opened the Individual Learning Center that provides video cassettes and interactive terminals for employees to study training material at their place. A local area network (LAN) was installed in one classroom with a gateway to the mainframe. Approximately 300 microcomputer and mainframe classes were conducted during FY 1989.

End-User Computing (EUC)—The Agency successfully defended two protests against the EUC procurement, and in April 1989, the HCFA Contracting Officer lifted the suspension on the IBM award. HCFA received approval for additional 1,100 work stations.

Data Communications—By late FY 1989, HCFA had replaced most Programmable Magnetic Tape Terminals sites. HCFA redesigned its remote data communications to use the VAN services via the National Library of Medicine contract. This VAN provides uniform communications between the HDC and Medicare contractors, CWF sites, HCFA Regional Offices, Peer Review Organizations, and State Agencies. Two T-1 Hyper channel circuits provide links to the SSA's National Computer Center.

Independent Verification and Validation—To ensure the software and database development deliverable meet HCFA's objectives. HCFA engaged a contractor to do an independent verification and validation technical review.

Systems Security—HCFA awarded a Hot-Site contract to COMDISCO. This organization would provide HCFA with an alternative data processing site following a disaster.

Procurement Goals

The Department of Health and Human Services set procurement preference and competition goals for FY 1989. A summary of the departmental procurement goals and HCFA's actual performance is shown in Table 8.

Recruiting Initiatives

In order to meet the Agency's ongoing need to identify, hire, and retain well qualified employment candidates, HCFA continued to develop and implement initiatives designed to bolster its recruitment programs. A variety of new Cooperative Education Program (Co-op) agreements were developed and/or initiated with a view toward improving minority recruitment and strengthening the pool of available college- educated candidates. To further these objectives, HCFA also attended

a variety of job fairs nationwide, and made a number of on -campus recruitment visits. The Agency also continued to expand its utilization of decentralized recruitment authorities, including the Delegated Examining Authority and Professional and Administrative Career Schedule B Authority. HCFA also provided extensive recruitment support to the quadrennial Social Security Advisory Council, including the hiring of a Senior Executive Service (SES)-level staff director and a senior level special assistant. Finally, in an effort to assist in the recruitment and retention of SES members, HCFA developed an Executive Orientation Handbook, which includes detailed information on both Federal employment and local area resources (housing, education, etc.).

Promoting Health, Wellness, and Fitness Programs

In an effort to promote health, wellness, and fitness awareness and program utilization among its employees, HCFA continued its initiatives to fully integrate these concepts. Extensive publicity efforts were made in relation to the Employee Assistance Program (EAP), including expanded training courses for managers, Equal Employment Opportunity Counselors, and personnel lists. Largely through these efforts, employee utilization of the EAP increased from 4.7 percent of the workforce to 6.1 percent. HCFA also continued to provide a wide variety of employee health screening programs, including low-cost mammograms and cost-free colon cancer screening. The Agency also initiated a program designed to revitalize its Fitness Center, primarily through increased internal controls and improved publicity efforts. Finally, HCFA made extensive efforts to prepare for implementation of the President's Drug Free Workplace initiative, including identification of testing designated positions, increased employee and supervisory education and awareness programs, and development of internal policies and procedures.

Development of Employees' Expertise

The education of personnel, from new employees to senior executives, in health care policy and operations is necessary for assuring a skilled, up-to-date workforce. For the first time, an orientation for new employees was conducted via the Social Security Administration's satellite network. Several hundred employees were briefed on major initiatives like "Effectiveness in Health Care." Three courses — Hospital Orientation Program, HCFA Budget Seminar, and Orientation to Managed Care —were held and three additional courses were under development. A committee was established to advise the training office on planning and evaluating in-house training. Individual managers were

Table 8

PROCUREMENT GOALS FOR FY 1989

CATEGORY	GOAL	ACTUAL	ACTUAL DOLLARS
Small Business	50.00 %	46.86%	$41,163,301
Section8(a)(SBA)	25.00	21.23	18,655,973
Direct Minority*	1.00	.63	560,472
Women-owned Business	5.00	5.75	5,079,671
Labor Surplus Areas	2.10	.51	451,904
Competitive	80.00	91.68	71,315,817

NOTE: Because there is no mandates set-aside authority for direct awards to minority firms, achievement of this goal was primarily dependent upon the minority owned enterprises submitting proposals for and winning competitive awards.

selected to attend health and public policy seminars conducted by the Brookings Institution, Cornell and Harvard Universities, and the University of Southern California.

Presidential Management Intern Program

The recruitment and development of talented analysts is essential to the Agency's mission of developing National health care policy and assuring the quality of services provided under Medicare and Medicaid. HCFA conducted a comprehensive program in support of the Office of Personnel Management's Presidential Management Intern (PMI) program . Thirty-four interns at HCFA were provided mentors, Individual Development Plans, training, a seminar series, and rotational assignments. A coordinator worked closely with the Interns and their supervisors and mentors to assure that interns were challenged and provided progressive development. The PMI program provides an excellent source for recruiting high caliber individuals with potential to become future leaders in HCFA.

Equal Employment Opportunity (EEO) Accomplishments

HCFA made some strides during the fiscal year with the increase in the total workforce from 3, 815 in FY 1988 to 3,977 in FY 1989.

The number of GS/GM 13-15 positions increased from 1,575 to 1,609. The number of minorities in this grade band increased from 199 to 200. Minority females increased from 101 to 104.

As in previous years, there was an objective for minority movement from nonprofessional positions into professional or administrative positions through the establishment of bridge or transitional positions. The objective was to place minorities in at least 52 percent of the available opportunities. During FY 1989, there were six opportunities and two (33 percent) went to minorities, as compared to seven minorities out of 17 opportunities in FY 1988. The Equal Opportunity Office (EOO) continues to monitor progress of the various components in achieving equity in the workforce for minorities, women and handicapped employees. EOO staff continues to work with the Office of Human Resources, Office of Budget and Administration, to assure that the appropriate workforce statistics are used to develop the Federal Equal Opportunity Recruitment Program update and goals for each fiscal year.

Table 9

EQUAL EMPLOYMENT OPPORTUNITY ACCOMPLISHMENTS

	FY 1988	%	FY 1989	%
Change in the HCFA Workforce	3,815		3,977	4.2
Representation of Minorities and Non-minorities Females in GS.GM 13-15 Positions	1,575	41.2	1,609	40.5*
Minorities	199	12.6	200	12.4
Non-minorities females	478	30.3	510	32.0
Representation of Handicapped Individuals In the HCFA Workforce	1,575	41.2	1,609	40.5
Individuals with Severly Handicapping Conditions	51	1.3	49	1.2*
GS/GM 13-15 Level	13	25.5	13	26.5
Severely handicapped	1	5.9	1	2.4

*Percent of total HCFA Workforce

Chapter VII

Significant Regulations Published In FY 1989

Certified Registered Nurse Anesthetists

HCFA published proposed regulation to implement the Certified Register Nurse Anesthetist (CRNA) fee schedule as mandated by P.L. 99-509, as amended.
Date of Publication: January 26, 1989

Physician Anesthesia Services

Proposed regulation to implement a uniform relative value guide for physician anesthesia services as mandated by P.L. 100-203.
Date of Publication: January 26, 1989

Payment for Physician Services in Teaching Settings

Proposed rule on Payment for Physician Services Furnished in Teaching Settings as mandated by Section 948, P.L. 96-499 and section 2307(a) of P.L. 98-369. The regulation defined a teaching physician and a teaching hospital for purpose of the payment rules; proscribed the criteria for qualifying for Part B payment; and established the methodology for determining payment.
Date of Publication: February 7, 1989

Radiology Fee Schedule

Interim final regulation on the Radiology fee schedule as mandated by P.L. 100-203. The regulation defined the radiology services included under the fee schedule and established payment for such services on a relative value scale.
Date of Publication: March 2, 1989

Payments for Certain Other Diagnostic Procedures Performed by Hospitals on an Outpatient Basis

HCFA developed instructions to implement section 4066 of OBRA 87. Under this provision, payment for certain other diagnostic procedures performed in hospital outpatient departments is determined based, in part, on what Medicare would have paid for the same services if they had been performed in a physician's office in the same locality.
Date of Publication: May 1989

Outpatient Drug Coverage

A proposed rule to implement section 202 of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) (MCCA), which established Medicare coverage and payment for a catastrophic level of beneficiary expenditures for covered outpatient drugs. This benefit would have provided coverage of outpatient prescription drugs on a much broader scale than was formerly available under Part B of Medicare.
Date of Publication: September 7, 1989

Home Intravenous Drug Therapy Services

A proposed rule governing expansion of coverage under Medicare Part B would have included coverage of home intravenous drug therapy services, as authorized by section 203 of MCCA.
Date of Publication: September 8, 1989

Home Intravenous Drugs

Also under section 203 of MCCA, HCFA published a proposed rule listing antibiotics, anti-infectives, hydration therapy drugs, pain management drugs, and other drugs and biologicals that we proposed as being safe and effective for use in the home.
Date of Publication: September 7, 1989

Home Intravenous Drug Therapy Providers -Conditions of Participation

We also published a proposed rule to set forth conditions of participation that an entity would be required to meet in order to qualify as a provider of home intravenous drug therapy services.
Date of Publication: September 7, 1989

Coverage of Screening Mammography Services

This proposed rule would have implemented section 204 of MCCA, to provide for coverage of screening mammography services.

Date of Publication: September 1, 1989

Medicare Coverage Regulation

HCFA published a proposed rule which describes the process and identifies the criteria that are applied when making national coverage decisions on the reasonableness and necessity of items, services and procedures under Medicare. The criteria include safety and effectiveness, experimental or investigational considerations, and appropriateness. The rule proposes, for the first time, that HCFA and the Medicare contractors that process claims also consider the cost-effectiveness of a service when making coverage decisions.

The purposed of the rule is to inform the public on how HCFA concludes that a national coverage decision is warranted, the source of information used, and the public's opportunity to participates in the process.

Date of Publication: January 30, 1989

Medicare Home Health Benefit

In August, 1989, HCFA published revised BPD-476-IFC, the Medicare Home Health Agency (HHA) Conditions of Participation. This regulation revised the Medicare HHA conditions of participation to include several statutory changes made by OBRA 87. Significant revisions include the enumeration of home health aide training and competency evaluation requirements. The latter provision required that, as of August 14, 1990, any individual furnishing home health aide services for a Medicare certified HHA must have successfully completed a home health aide training and competency evaluation program, or competency evaluation program, that meets the standards of the revised conditions. These and other changes made as a result of the OBRA 87 revisions represent a significant advance in the implementation of the Congressional intent to protect and promote home health patient health and safety.

Date of Publication: August 14, 1989

Medicare Skilled Nursing Facility Benefit

Final regulation establishing new requirements for participation for Medicare skilled nursing facilities (SNFs). The regulations were based on the recommendations of a 1986 report of the National Academy of Sciences Institute of Medicine, a 1987 proposed rule based on those recommendations and the nursing home reform provisions of OBRA 87. They contain a variety of new requirements relating to resident assessment and care planning, residents' rights, quality of care and quality of life. A key feature of the new regulations is their focus on outcome measures of compliance (i.e., actual positive results of care) rather than on process measures (i.e., existence of institutional capacity to produce positive results).

Date of Publication: February 2, 1989

Chapter VIII

Reports and Publications

HCFA publishes a variety of reports and publications dealing with the Medicare program. Those publications listed in this chapter may be of particular interest to Congress as well as to the public.

HCFA's Office of Research and Demonstrations publishes reports and publications covering research and demonstration activities and statistical information on the Medicare and Medicaid programs. These include:

Status Report: Research and Demonstrations in Health Care Financing – Provides basic information in a brief format on the approximately 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

Health Care Financing Review (Quarterly journal plus Annual Supplement) – HCFA's quarterly research journal reports findings related to health care financing and delivery. Includes trends data that highlight economic developments in the health care sector and announcements of new HCFA research publications and projects. The Review is available on a subscription basis ($13.00 per year) from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Medicare and Medicaid Data Book – Presents a broad overview of the Medicare and Medicaid programs and their operation and use, including data on enrollment, utilization, providers, payment, and recipient.

Health Care Financing Project Reports – Includes brief reports on individual research and demonstration projects that provide an overview of the project and major findings or results and information on obtaining related publications.

Health Care Financing Special Reports – Reports on single themes, providing comprehensive coverage of important issues in health care financing.

National Medical Care Utilization and Expenditure Survey Reports – Reports on the survey findings, including information on access to and use of medical care, health and demographic characteristics of persons and families, and the sources and costs of services.

Ordering Information

Placement on the mailing list for notification of all Research and Demonstrations (R&D) reports as they are published and single complimentary copies of publications, with the exception of the *HCFA Review*, are available, along with additional information on the R&D publications program by writing to:

Health Care Financing Administration
Office of Research & Demonstrations
Publications and Information Resources Branch
Room 1-A-9 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207

Single copies of the following beneficiary publications are available by written request to:

Office of Public Affairs
Health Care Financing Administration
403-B Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Guide to Health Insurance for People with Medicare – Provides information to Medicare beneficiaries regarding supplemental health insurance policies. Publication Number 02110

Hospital Mortality Information Release – This issuance presents a list of mortality rates and predicted ranges of mortality for each of the approximately 6,000 acute care hospitals treating Medicare patients. This information is designed to assist hospitals in working to improve the care they provide and to give customers valuable information in making decisions when seeking hospital care. Publication Number 00720 through 00733.

Medicare and Prepayment Plans – To encourage the use of Health Maintenance Organizations (HMOs) by Medicare beneficiaries and explain the Medicare benefits and services available through HMOs. Publication Number 02195.

Medicare Annual Reports (1985 & 1986) – This publication provides Congress and other interested parties with a detailed report on the performance of the Medicare program for the subject fiscal year. Publication Number 02186.

Medicare Has Improved: Catastrophic Protection and Other New Benefits – An official notice to Medicare beneficiaries explaining benefits under the Medicare Catastrophic Coverage Act of 1988, which limits the amount payable for hospital care, physician services, medical supplies and outpatient drugs. Publication Number 01010.

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services A Supplement to Your Medicare Handbook – To explain Medicare/ Medicaid benefits to beneficiaries involved in the end-stage renal disease (ESRD) and the special rules that apply to the coverage and payment. Publication Number 10128.

Second Opinion – This publication addresses the more than nine million Americans who annually have surgery and encourages the public to seek a second opinion when non-emergency surgery has been recommended. Publication Number 02173.

The Medicare Handbook (English) – This book provides a basic description of Medicare benefits, intended to inform beneficiaries of their rights and benefits under the program, how to apply for benefits, and their responsibilities regarding payment for premiums, deductibles, coinsurance and other requirements of the program. It also provides notices to beneficiaries as required in P.L. 100-360. Publication Number 10050.

Su Guia De Medicare (Spanish Handbook) – Publication Number 10950.

The Medicare Handbook (Braille) – To provide access to information about their rights and responsibilities under the Medicare program for blind Medicare beneficiaries. Publication Number 10051.

Your Hospital Stay Under Medicare's Prospective Payment System – To inform Medicare beneficiaries about the Prospective Payment System (PPS) and how it affects them. Publication Number 02163.

An Important Message: If you want Medical Insurance Under Medicare – This publication is sent to certain individual to explain the enrollment procedure and serve as a cover letter for the accompanying informational pamphlet and enrollment application.

Budget and Legislative Program—Fiscal Year 1991-HHS – HCFA's budget and legislative programs presented in detail as required in the outlined Departmental instructions. This book is also printed to specify in final form the budget data needed to provide the Department's personnel with knowledgeable budgetary needs for each of HCFA's program activities.

Compendium of National Health Expenditures Data-DHHS – This publication presents in one volume, detailed estimates of health spending from the National Health Accounts (AHA) for the years 1960 through 1987. These estimates incorporate extensive revision to NHA, including presentation of new, detailed estimates, revisions in concepts, and new methods and data sources.

Demonstrations and Designs of Alternative Reimbursement Methods for Home Health Services-DHHS – A synthesis of current knowledge and research on home health care providers and clients, and in particular summarizes the results of demonstration projects and design efforts relating to alternative payment methods. Publication Number 03290.

Hospice Benefits Under Medicare-DHHS – A pamphlet describing the special rules of coverage for care in a hospice program. Publication Number 02154.

Health Care Financing Administration Rulings-DHHS – To interpret and clarify complex or ambiguous statutory or regulatory provisions affecting the Medicare and Medicaid programs, to adopt certain court and hearing decisions as policy, and to inform interested members of the public of our interpretations. Publication Number 10009.

High Volume and High Payment Procedures in the Medicaid Population-DHHS – A number of States are attempting to control Medicaid expenditures by instituting mandatory second opinion or preadmission review programs. This report to Congress is a presentation of data identifying surgical procedures that are high in volume or high in payment and therefore likely candidates for inclusion in such programs. Publication Number 03289.

ICD-9-CM, International Classification of Diseases 9th Revision, Clinical Modification, Volume 3-DHHS – To provide updated version of ICD-9-CM to all users. The Department of Health and Human Services (DHHS) requires ICD-9-CM for use in reporting diagnostic and procedural services provided by hospitals. HCFA has the responsibility for maintaining the procedure section of DCD-9-CM, Volume 3. Publication Number PHS 88-1260.

Medicare and Employer Health Plans HHS – The pamphlet explains the law which requires employers to offer employed Medicare beneficiaries age 65 or older the same health insurance plan that they offer to their younger employees. (HCFA 02150).

Maternal and Infant Health: Medicaid Strategies to Save Lives and Money HHS – To help reduce infant mortality by maximizing Medicaid coverage and benefits for pregnant women and infants.

Medicaid Services State by State Chart-HCFA – The overall purpose of the chart is to communicate via a thumbnail sketch the comprehensiveness of the Medicaid program as both a national and a State effort. (HCFA-02155).

Medicaid Surveillance & Utilization Review Best Practice Guide-DHHS – This publication will enable State agencies to improve and enhance their ability to measure the extent of utilization abuse occurring in the Medicaid Program. The Guide will include eight SUR best practices. The individual practices will be sufficiently detailed so that State agencies will be able to assess the applicability of each best practice to their own State operation and implement that practice, if appropriate.

Medicaid Third Party Liability - A State's Opportunity-BQC/OMM/DPS – This publication serves as a marketing tool for HCFA's National TPL Marketing Strategy. Implementing the TPL strategy is a major workplan initiative for 1989.

Medicare Catastrophic Information for HMO/CMP Enrollees-HCFA/OPA – The purpose of this notice is to provide Medicare members of health maintenance organizations (HMOs) and competitive medical plans (CMPs) with information about the Catastrophic Act of 1988 and this law's impact on their prepaid health plan coverage. Publication Number 10008.

Nursing Home Information Release-DSMDA – To provide the general public and nursing home communities with knowledge of the population and performance of all nursing homes that participate in the Medicare or Medicaid program.

Notice to Medicare Beneficiaries-HCFA – This notice is to inform selected Medicare beneficiaries of a new provision of the Medicare Catastrophic Coverage Act of 1988. This complicated provision is covered only in a very general way in the Medicare Handbook in order not to confuse beneficiaries.

Proper Procedures for Filing with Medicare as a Secondary Payer DOI – (1) To provide Medicare contractors with a resource guide for responding to inquires, in training of new staff on Medicare Secondary Payer (MSP) billing procedures, training new personnel in physicians offices, to use as handouts at workshops, seminars and in response to requests for copies of the pamphlets, and (2) to provide MSP Outreach staff at both Central and Regional Offices with educational tools to better educate contractors, providers, physicians, suppliers, beneficiaries and beneficiary-related groups about MSP provisions. No Publication Number.

Report to Congress: Medicare Physician Payment-DHHS – Medicare Physician Payment contains three congressionally mandated reports, each dealing with a proposed change in physician payment. It is a logical follow-up to the Impact of the Medicare Hospital Prospective Payment System series of Reports to Congress, as it is a presentation of ways to control Medicare program costs in another significant area. Publication Number 03287.

Report to Congress & the Administration of HCFA by the Advisory Committee on Medicare Home Health Claims-BPO – The report is required by Congress to recommend needed reforms for the process at home health care denials in 1986 and 1987. Publication Number 02181.

Report to Congress and the Secretary by the Task Force on Long Term Health Care Policies – Publication Number 0218.

Report to Congress: Medicare Physician Payment – Medicare Physician Payment contains three congressionally mandated reports, each dealing with a proposed change in physician payment. This report is a follow-up to the Impact

of the Medicare Hospital Prospective Payment System series of Reports to Congress. Publication Number 03287.

Small Area Hospital Data for Aged Medicare Beneficiaries (2 Volumes) -DHHS – These publications provide detailed information on utilization of hospital services and the outcomes of these services provided to Medicare beneficiaries. Volume 1, Publication Number 03300, Volume 2, Publication Number 03303.

Task force on Technology-Dependent Children-IOA – To identify barriers and make recommendations for technology-dependent children. Publication Number 02171.

The Medicare Fact Sheet-OAAC/OPA – A leaflet explaining the Catastrophic coverage to eligible Medicare beneficiaries.

The Presidential Management Intern Program at the HCFA-HCFA – This pamphlet communicates information about HCFA and its PMI program to PMI finalists. The information contained is intended to generate interest among the finalists in the management of Federal health care financing programs.

Working Papers (Internal documents) Requesting Blanket Clearance for ORD Publications Coordination-HCFA – Working Papers series is used to reproduce a limited number of reports and background papers produced by the programs for distribution among internal audiences and used for information, decision making, and policy development.

1989 Data Users Conference Proceedings-BDMS/OSDM – To disseminate information which expresses an overview of the type of Medicare and Medicaid data available in HCFA as strategized in the June 13-15, 1989, Data Users Conference. Publication Number 03293.

1989 HCFA Common Procedure Coding System (HCPCS)-OPOP/DCP – An annual listing of procedure HCPCS codes used by physicians, billing services and medical suppliers.

Chapter IX

Medigap Voluntary Certification Program Report

Introduction

Congressional studies conducted prior to 1980 found many abuses in the sale and marketing of Medicare supplement or "Medigap" health insurance. There were no Federal standards for Medicare supplement coverage and few States had adopted programs specifically to regulate these types of policies. In June 1980, Congress enacted Public Law 96-265, which added Section 1882 to Title XVIII of the Social Security Act. This law, usually referred to as the Medigap law, initially was opposed by insurance regulators and the insurance industry. The regulation of the business of insurance had traditionally been the responsibility of the States under the McCarran-Ferguson Act of 1945, and the Medigap law was perceived by some as an encroachment upon States' rights. This perception resulted from a fear that the Federal Government would necessarily become greatly involved in individual insurance department operations in order to enforce the law. This has not proved to be the case, however, and the relationship between the Federal Government and the States has been a cooperative one. State and Federal agencies are working together toward the common goal of providing the best protection available for elderly citizens.

Provisions of Medigap Law

The Medigap law established Federal minimum standards based primarily on the provisions contained in the 1979 National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act. The law, however, expands upon the model's requirements by extending its jurisdiction to certain group policies and by adding loss-ratio requirements for both group and individual policies. In addition, it provides for the establishment of the Supplemental Health Insurance Panel and a Federal Voluntary Certification Program for Medicare supplement policies. It also includes criminal penalty provisions for certain abusive sales practices.

The law further requires the Secretary of HHS to submit to Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section.

The Voluntary Certification Program

Under the Voluntary Certification Program, insurers selling Medigap policies not previously approved by the Supplemental Health Insurance Panel, may submit the policies for review and approval to the Secretary of HHS. Those policies found to meet or exceed the Federal minimum standards will be certified, and the insurer will be authorized to display a Federal emblem on the policy. This emblem is authorized for use only in States subject to the Federal program, regardless of whether the same policy is marketed in States not under the program.

Participation

In July of 1982, the Panel determined that the Voluntary Certification Program should be implemented in four States (Massachusetts, New York, Rhode Island, and Wyoming) and three territories (Guam, the Virgin islands, and American Samoa) because they had not incorporated all of the Federal requirements

into their regulatory programs. There have, however, been few submittals under the Voluntary Certification Program and no policies have actually been certified by the Secretary to date. As explained earlier, policies marketed in Panel-approved States are "deemed" certified. Nonetheless, these policies are not authorized to display the Federal emblem. Only those policies actually submitted and approved by the Secretary under the Voluntary Certification Program are authorized to display such emblem.

Since 1982, the Panel has monitored the continued compliance of Panel-approved States via annual recertifications and has periodically contacted the nonapproved States to determine if any changes have occurred which would allow for Panel approval. The status of State programs under Section 1882 remained unchanged until 1989, when States were required to amend their Medigap programs to incorporate changes in Section 1882 required by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and the Medicare Catastrophic Coverage Act (MCCA) of 1988. Due to these changes, the Panel was required to review completely all State programs and approved all but the programs of Massachusetts, American Samoa, and Guam.

Impact

Since the Secretary has not yet certified any policies under the Voluntary Certification Program, there is no data available to show the direct impact of the certification procedure on market share, value, and cost to individuals entitled to benefits under Title XVIII. As stated earlier, however, the indirect impact of the program has been its positive effect of prompting States to implement their own approved regulatory programs for Medicare supplement policies. Without the incentive provided by the Voluntary Certification Program, it is doubtful that as many States would have changed their programs. Also, the Supplemental Health Insurance Panel's monitoring of the continued compliance of the approved States, and the Voluntary Certification Program, should act as deterrents to those States considering changes to their regulatory programs that would adversely affect their continued compliance with the Medigap law.

The Medigap law also established Federal criminal penalties for certain fraudulent or abusive marketing practices. Section 1882(d) provides criminal sanctions for furnishing false or misleading information for the purposes of obtaining certification; for misrepresentation as an agent of the Federal Government for the purpose of selling insurance to supplement Medicare; for knowingly selling insurance which substantially duplicates benefits of another policy held by the purchaser; and for knowingly advertising, soliciting, or offering for sale mail-order policies in a State without the approval of the State insurance commissioner. Anyone convicted of violations of Section 1882 is subject to a fine of up to $25,000 and/or imprisonment for up to five years.

Implementation

HCFA, given the responsibility for implementing the penalty provisions of the Medigap law, continues to investigate possible violations of Section 1882(d). The agency has developed a coordinated system for reporting these violation that includes the 10 HCFA regional offices, the SSA, HHS, OIG, and the Department of Justice (DOJ).

The initial screening of complaints is generally done through HCFA's regional offices. These offices are also responsible for furnishing information to State insurance departments about specific complaints. The OIG investigates complaints that have been referred to it by HCFA and coordinates this activity with State insurance departments. The OIG also serves as the liaison between State insurance departments and U.S. Attorneys, who have been contacted by the Fraud Division of the DOJ regarding the Medigap

law and encouraged to prosecute violations of this section.

HCFA also receives occasional complaints about practices which, while not in violation of the Medigap law, are possible violations of other Federal statutes. These most often involve misleading advertising and mail order solicitations for Medicare supplement insurance. HCFA's efforts in this area are coordinated with other Federal agencies such as the Federal Trade Commission and the Postal Inspection Service.

Activity in Fiscal Years 1988 and 1989

HCFA continued to investigate potential violations of Section 1882(d) of the Medigap law and was notified of 8 possible violations in FY 1988 and 7 in FY in 1989. All of these cases were closed out due to either a lack of evidence or to referral to specific State insurance departments for investigation of possible violations of State laws. Additionally, three cases pending from prior fiscal years were closed out. Concerning compliance of State regulatory programs, all of the States originally granted Panel approval were recertified to ensure that they continue to maintain programs that meet the Federal minimum standards. HCFA also continues to respond to public and congressional inquiries regarding Medicare supplement insurance.

Difficulties in Prosecution

Witness reliability has continued to be a problem in getting cases prosecuted under Section 1882. The elderly often become confused under questioning, and prosecutors are reluctant to charge agents under Federal law, since criminal penalties are indicated. They believe that administrative penalties would be more appropriate in many cases.

There remains interest at the State level in utilizing Federal penalties to prevent abuse and fraud in the sales and marketing of Medigap policies. Most States still do not have specific laws for violations involving Medicare supplement health insurance. As indicated, however, getting these types of cases prosecuted under Federal law has proved difficult, and there have been no convictions to date under this law. At the present time, it is believed that it is in the best interest of elderly citizens to continue the penalty provisions of Section 1882 to keep available the option of prosecution under Federal law.

Chapter X

Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Health Care Organizations

Introduction/Statutory Background

Section 1875 of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (DHHS) to validate the accreditation process of the Joint Commission on a continuous basis. The purpose of the validation program is to determine whether the Joint Commission's accreditation process provides reasonable assurance that accredited hospitals comply with the Medicare requirements as described in section 1865 of the Act. This section also requires the Secretary of DHHS to submit an annual report to Congress on the findings of the validation process.

Each year, the Health Care Financing Administration (HCFA) selects a statistical sample from the approximately 5,200 accredited hospitals for validation surveys. Validation surveys are also conducted in response to substantial allegations of the existence of a significant deficiency or deficiencies which would, if present, adversely affect the health and safety of patients. Validation surveys are conducted by the Medicare State survey agencies (SAs) as authorized by section 1864(c) of the Act. During FY 89, the SAs conducted 155 sample validation surveys and investigated 582 complaints which led to 57 full allegation surveys. These numbers do not include investigations of alleged violations of section 1867 of the Act (examination and treatment for emergency medical conditions and women in labor). This report analyzes the findings from the validation and allegation surveys.

Accreditation Process

The Joint Commission's accreditation survey assesses a hospital's compliance with the Joint Commission's standards. After the completion of the onsite survey, the Joint Commission makes an accreditation decision. A hospital may receive a 3-year accreditation with or without a contingency or, in cases where a hospital fails to achieve substantial overall compliance, no accreditation. A contingency stipulates that the accreditation will be withdrawn if the hospital fails to correct its deficiencies within a specified amount of time. The Joint Commission, through the use of focused onsite resurveys and/or written progress reports prepared by the hospital, determines whether the hospital has corrected the deficiencies necessary to retain accreditation. The contingency accreditation process is analogous to the Medicare resurvey as both assess correction of deficiencies. In 1989, the Joint Commission created a new "conditional accreditation" category as a possible survey outcome. Conditional accreditation procedures became effective for accreditation surveys conducted on or after July 1, 1989. The conditional accreditation procedures are applicable to hospitals that may be subject to non-accreditation decisions and are designed to prompt these marginal hospitals to expedite efforts to improve performance.

In 1989, the Joint Commission made accreditation decisions for 1,752 hospitals. Table 10 lists the types of accreditation decisions made by the Joint Commission and the number and percentage of hospitals receiving those decisions.

Table 10

JOINT COMMISSION ACCREDITATION DECISIONS SURVEYS CONDUCTED IN CALENDAR YEAR 1989

TYPE OF DECISION	NUMBER OF HOSPITALS	PERCENT
Unencumbered accreditation without contingencies	27	1.5
Accreditation with written progress report (WPR) contingencies	195	11.1
Accreditation with follow-up visit contingencies	237	13.5
Accreditation with WPR and follow-up visit contingencies	1,218	69.5
Conditional accreditation *	61	3.5
Conditional accreditation attributable to hospital-based long-term care, ambulatory, home health or mental health	2	0.1
Denial of accreditation (in appeal process)	3	0.2
Denial of accreditation	3	0.2
Tentative nonaccreditation	6	0.4

* Conditional accreditation category instituted July 1, 1989

The Joint Commission survey team is composed of a physician, a registered nurse, a hospital administrator trained in the evaluation of the Life Safety Code (LSC) requirement, and a medical technologist. The medical technologist may not always be present on the survey as the Joint Commission reviews and includes the recommendations by the College of American Pathologists (CAP), in the Joint Commission Accreditation Report. Approximately 46 percent of the Joint Commission Hospitals have laboratories accredited by CAP. Although the Joint Commission's requirements are comparable to the Medicare Conditions of Participation (COPs), there are numerous differences in the specific requirements. The format of the Joint Commission's standards and the survey report form they use to assess compliance are far more detailed than HCFA's.

Validation and Allegation Process

Medicare Survey Process

The accredited hospitals are surveyed by the SAs using the Medicare COPs for hospitals. In the case of a hospital selected for a sample validation survey, the SAs are requested to schedule their surveys within 60 days after the Joint Commission accreditation survey. This allows HCFA to evaluate the ability of the Joint Commission to identify deficiencies similar to those identified by the SAs.

However, in this reporting period, the Joint Commission inadvertently provided focused survey dates which caused HCFA to schedule some validation surveys based on the focused survey date rather than the accreditation survey date. Focused surveys are on-site follow-up visits to verify correction of problems in selected requirements that were identified in the earlier accreditation survey.

Because focused survey dates were provided, 45 of the 155 validation surveys were performed within 60 days after the focused survey but in excess of 60 days after the accreditation survey. Since the validation program compares findings from the accreditation surveys with findings from the validation surveys, the 45 surveys conducted in excess of the 60 day limitation were analyzed to evaluate the ability of the Joint Commission to ensure hospital compliance throughout the 3 year accreditation period.

Instructions to the SAs require that the survey be conducted on successive days in an objective manner without reference to accreditation findings. The validation team is not furnished a copy of the accreditation report and is told not to inquire about the accreditation survey findings.

The composition of the SA teams varies from State to State. Most of the States use a multidisciplinary team with representation from professional nursing, dietary, pharmacy, medical records, hospital administration and laboratory science specialties. Some States have physicians who act as consultants to members of the team. All States use fire safety professionals (e.g., fire marshals) to determine the extent of compliance with provisions of the LSC of the National Fire Protection Association (NFPA).

The survey process uses the "deficiency" as the primary measure of hospital quality of care. There are three deficiency severity levels. The condition level is the most severe. This level indicates the facility is seriously limited in its capacity to furnish an adequate level of quality of care. Standard level deficiencies are somewhat less severe. Elements, also called factors, are the least severe. While an institution may fail to comply with one or more of the subsidiary standards or elements during any given survey, it cannot participate in the Medicare program unless it meets each and every condition level requirement.

If an accredited hospital is found to have condition level deficiencies, it is no longer deemed to meet the COPs. The hospital then becomes subject to SA surveillance under the same procedures applied to nonaccredited hospitals. Should the hospital not correct its deficiencies in accordance with an acceptable plan, the hospital is terminated from the Medicare program. When HCFA determines that the hospital no longer has condition level deficiencies, SA monitoring of the institution is discontinued, and the hospital is again deemed to meet the Medicare COPs by virtue of its accreditation, and the Joint Commission is responsible for ensuring that any remaining deficiencies are corrected.

Selection Basis

For sample validation surveys, HCFA selects a statistical sample from the Joint Commission's schedule of hospital accreditation surveys. The stratified random sample reflects the urban-rural mix and the range of sizes of participating hospitals. This permits HCFA to apply the findings to the universe of accredited hospitals. In an effort to increase the value of the analysis, the number of sample validation surveys was increased from 98 in FY 1988 to 155 in FY 1989. The 155 hospitals in this study have an average total bed capacity of 194 beds, with a range of 20 to 1158 beds. Because the Joint Commission inadvertently provided focused survey dates rather than full-survey dates, 45 hospitals received a validation survey in excess of 60 days after the accreditation survey. The average time between the Joint Commission and the SA surveys for these 45 hospitals was 280 days. The average time between the Joint Commission survey and the SA survey for the 110 hospitals surveyed within 60 days was 44 days.

In addition to the sample surveys, an accredited hospital is also subject to a SA survey when there is an allegation that conditions threaten the health and safety of patients.

Based on the nature of the complaint, allegation surveys evaluate only those specified Medicare COPs as authorized by HCFA's regional offices. If the SA finds a condition level deficiency, the hospital is no longer deemed to meet the Medicare COPs and is placed under SA monitoring until the condition level deficiency is corrected. The hospital is then subject to a full survey of all the COPs. As stated earlier, 582 complaint investigations were performed during fiscal year 1989, and 57 hospitals were placed under SA monitoring.

Evaluation Methodology

This report contains an analysis of the deficiencies identified in the SA validation surveys and the Joint Commission accreditation surveys conducted during the 1989 reporting period. The Joint Commission's letters of recommendation and the HCFA Statement of Deficiencies (HCFA Form-2567) were used to identify each hospital's deficiencies. A crosswalk was developed by HCFA and the Joint Commission which assigned a Federal data tag to each Joint Commission requirement that is comparable to a Federal requirement. Strict comparability of these findings is limited, because overall, Joint Commission requirements are much more detailed than the Medicare conditions of participation.

Data Elements—The Joint Commission surveys were conducted between February 1987 and November 1989, with 96 percent (148 of 155) conducted in 1988 and 1989. The SA surveys were conducted between May 1988 and January 1990, with 99 percent (153 of 155) conducted in 1988 and 1989. Seventy-one percent (110 of 155) of the SA surveys were conducted within 60 days after the Joint Commission survey. An additional 17 percent (27 of 155) of the surveys were conducted within 1 year after the Joint Commission survey. Twelve percent (18 of 155) of the surveys were conducted in excess of 1 year after the Joint Commission survey.

This report examines deficiency data for 19 of the 20 Medicare COPs. The Utilization Review condition was not surveyed by the SAs because the accredited hospitals are all subject to binding review by their State Peer Review Organizations (PROs). The Medicare utilization review requirements do not apply when a PRO has assumed binding review for the hospital.

Survey findings were analyzed in terms of the number, nature, and types of requirements found out of compliance (deficiencies). The number of deficiencies refers to the total number of health and safety and LSC deficiencies cited in the sample validation hospitals. There are a maximum of 263 health and safety requirements, 232 additional laboratory requirements contained in Form HCFA-1557, and 87 LSC requirements per survey.

Tests—A t-test, a parametric statistical procedure, which assumes the data are ordered by magnitude and have equal intervals and are normally distributed (i.e., a bell shaped curve), was used to test for difference. The deficiencies were totalled and tested to verify that they are normally distributed. Then a t-test was calculated for the number, nature, and type of deficiencies. An observed significance level of 0.05 was used throughout the analysis. Statistical analysis was used to explore the hypothesis that the deficiencies found during Joint Commission accreditation surveys were significantly different from those found during SA validations surveys. We are particularly interested in differences at the condition level, since that could indicate problems with survey comparability.

Fiscal Year 1989 Analysis

Sample Validation Surveys - Number of Deficiencies

For the FY 1989 reporting period, the SAs conducted 110 validation surveys within 60 days after the Joint Commission survey. Approximately 26 percent (29 hospitals) failed to comply with the Medicare COPs and were placed under SA monitoring. Forty-five hospitals received validation surveys in excess of 60 days after the Joint Commission survey. Approximately 36 percent (16 hospitals) of those hospitals failed to comply with the Medicare COPs and were placed under SA monitoring. See Appendix A. The numbers of conditions, standards, elements and LSC deficiencies identified during each survey can be found in Appendix B. None of the 45 hospitals found out of compliance with the COPs were terminated from participation in the Medicare program since each of the hospitals corrected its deficiencies before the termination date was reached.

While it appears that the SAs identified virtually the same number of general health and safety deficiencies as did the Joint Commission (2,186 versus 2,180 in the within 60 day, 974 versus 929 in the over 60 day surveys), it should be noted that 54 of the 155 hospitals' laboratories are CAP accredited and laboratory deficiencies were not available for comparison with SA findings. Thus, the SAs actually identified fewer health and safety deficiencies (1,442 versus 1,832 in the within 60 day, 687 versus 734 in the over 60 day surveys) than did the Joint Commission when the laboratory deficiencies are excluded from the analysis. However, the SAs identified almost 5 times (809 versus 171) as many LSC deficiencies as did the Joint Commission during the surveys conducted within 60 days after the Joint Commission surveys and almost 4 times (293 versus 74) as many in the surveys conducted in excess of 60 days after the Joint Commission surveys.

When the data were statistically analyzed, there was no significant difference in the number of health and safety deficiencies between the validation and accreditation surveys. There was, however, a significant difference in the number of LSC deficiencies identified, with the Joint Commission identifying far fewer than would occur by chance alone.

Sample Validation Surveys - Type of Deficiencies

Data analysis found significant differences in 8 deficiency type categories (Federal, State and Local Laws, Governing Body, Quality Assurance, Medical Staff, Pharmaceutical Services, Laboratory Services, Food and Dietetic Services, Infection Control) for surveys conducted within 60 days. Analysis revealed significant differences in 5 deficiency type categories (Federal, State and Local Laws, Quality Assurance, Pharmaceutical Services, Food and Dietetic Services, Infection Control) for surveys conducted in excess of 60 days.

The Joint Commission found more deficiencies in Governing Body, Quality Assurance, Medical Staff and Infection Control in those hospitals they surveyed primarily in 1989, and more deficiencies in Quality Assurance and Infection Control in those hospitals surveyed prior to 1989.

The SAs found more deficiencies in Federal, State and Local Laws, Pharmaceutical Services, Laboratory Services, and Food and Dietetic Services in the within 60 day surveys. The SAs found more deficiencies in Federal, State and Local Laws, Pharmaceutical Services, and Food and Dietetic Services in the greater than 60 day surveys.

Sample Validation Findings - Nature of the Deficiencies

The SAs cited over twice as many condition level deficiencies during validation surveys as does the Joint Commission during its accreditation surveys (60 versus 26 in the

within 60 day surveys, 28 and 12 in the over 60 day surveys). The SAs and the Joint Commission cite approximately the same number of standard (342 versus 420 for the within 60 day surveys, 162 versus 143 for the within 60 day surveys) and element level deficiencies (1774 versus 1734 for the within 60 day surveys, 784 versus 771 for the over 60 day surveys).

Statistical analysis revealed a significant difference for the condition level deficiencies in the within 60 day surveys. The conditions most frequently cited by the SAs were Quality Assurance (17 hospitals), Physical Environment (17 hospitals), and Laboratory Services (12 hospitals). (Appendix C).

Allegation Survey Findings

During FY 1989, there were 57 full allegation surveys conducted (Appendix D). From FY 1988 to FY 1989, the percentage of hospitals found out of compliance with the Medicare COPs and LSC increased slightly (14 percent versus 10 percent). Ninety-three percent (53 of 57 hospitals) were found out of compliance with the Medicare COPs excluding the LSC, 5 percent (3 of 57 hospitals) were found out of compliance with the LSC only, and 2 percent (1 of 57 hospitals) were found out of compliance with at least one Medicare COPs and the LSC (Appendix E). Results of investigations into allegations showed that in the 57 hospitals placed under SA surveillance, the most frequently occurring deficient conditions were Quality Assurance (37 percent), Nursing Services (28 percent), Medical Staff (18 percent), and Physical Environment (16 percent). (Appendix F).

Discussion

Number of Deficiencies

There is no significant difference between the number of health and safety deficiencies identified by the SAs and the Joint Commission. In fact, the Joint Commission identifies more health and safety deficiencies when the data are corrected to reflect HCFA's lack of access to the laboratory deficiencies identified by the CAP.

The LSC of the NFPA, a consensus standard adopted by reference in Federal regulations, provides a reasonable level of safety from fire and other emergencies. LSC for fire safety has been one of the most difficult requirements to meet for both accredited and nonaccredited hospitals. The percentage of hospitals with major LSC deficiencies cited in the sample validation hospitals from FY 1988 to FY 1989 declined slightly—13.3 percent (13 of 98 hospitals) in FY 1988 to 11 percent (17 of 155 hospitals) in FY 1989 (Appendix C). For all previous report periods, 42 percent (467 of 1,086 hospitals) of the hospitals were found out of compliance with the LSC, Appendix G.

The increase in LSC compliance in the past two years (FY 1988 and FY 1989) compared to all previous report periods may be attributed to our application and enforcement of the Fire Safety Evaluation System (FSES). The FSES was developed by the National Institute of Standards and Technology to permit a health care facility to employ alternative measures for meeting the LSC requirements while providing an equivalent level of fire safety. The FSES is now part of the LSC. However, this study found a significant difference between the number of LSC violations identified by the SAs and the Joint Commission. The SAs identify 4 to 5 times more violations than does the Joint Commission.

Type of Deficiencies

The Joint Commission identifies more deficiencies in Quality Assurance and Infection Control than do the SAs. This reflects the Joint Commission's program emphasis in the past several years.

The SAs identify significantly more deficiencies in Federal, State and Local Laws, Pharmaceutical Services, and Dietetic Services than does the Joint Commission. Without access to CAP findings it is impossible to determine whether the SA finds greater num-

bers of Laboratory Services deficiencies. HCFA expects the SAs to find more Federal, State, and Local Law deficiencies because the SAs are also the licensing entities in their States. The larger number of pharmaceutical and dietetic deficiencies cited by the SAs probably reflects survey team composition, in that the SAs often use pharmacists and dietitians as consultants and surveyors.

Nature of Deficiencies

In FY 1989, the COPs most frequently found out of compliance were Quality Assurance (17 hospitals), Physical Environment due to LSC (17 hospitals), and Laboratory Services (12 hospitals). These have been the most frequently cited COPs since 1987 when the Quality Assurance condition was introduced.

The Joint Commission does not have overarching requirements which are comparable to the condition level, but rather uses a decision grid. Much of the difference in severity level between the SAs and the Joint Commission in the within 60 day surveys can be attributed to the fact that the decision grid has not yet been incorporated into the crosswalk used in this analysis. Regardless, there was no significant difference in deficiency severity in the greater than 60 day surveys.

Allegation Surveys

For allegation surveys, the data show a decrease in the percentage of hospitals found to have one or more conditions out of compliance as a result of allegation investigations. Of the 582 hospitals surveyed as the result of substantial allegations, 10 percent were not in compliance with one or more conditions of participation as compared to 14 percent from the last report period. The complaint pattern reflects the origin of the complaints, that is, most complaints are made by patients and their families, and most deficiencies identified in these surveys are patient care deficiencies.

Conclusions and Recommendations

Our analysis of all aspects of the Joint Commission's performance based on validation and complaint surveys indicates that, in general, Joint Commission accreditation does in fact provide reasonable assurance that accredited hospitals meet Federal requirements. Our analysis also leads to some specific conclusions about particular aspects of the Joint Commission's accreditation program as well as State agency survey operations and HCFA's continuing oversight of these programs:

- Meeting quality assurance requirements is problematic for all hospitals.
- The Joint Commission enforces quality assurance and general health requirements more vigorously than do State agencies.
- State agencies apparently have more expertise and more vigorously enforce LSC requirements.
- The Joint Commission is improving its timeframes for making accreditation decisions and taking follow-up actions to ensure correction of problems.

These conclusions lead to the following recommendations which we will pursue over future months:

- The Joint Commission should continue to stress the importance of LSC training for their surveyors so that they can continue to improve their evaluation of hospitals for LSC compliance.
- HCFA needs to take steps to strengthen State agency enforcement of health and quality standards.
- HCFA has been focusing on training as the method to strengthen state agency enforcement by conducting basic surveyor training courses at least 8 times a year. The courses train surveyors in skills that are generic to all surveys. HCFA also developed a training manual on documentation of facility deficiencies.

- The Joint Commission should continue to refine its decision making processes to ensure timely follow-up on problems identified through its inspection process.
- HCFA needs to continue to analyze information on the Joint Commission's enforcement processing timeframes and work with the Joint Commission, as necessary, to ensure quick and effective response to substandard hospital performance.

APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION I				
07-0027 Manchester Memorial Manchester, CT	206	3 - year accreditation	met	—
20-0038 Mount Desert Island Bar Harbor, ME	49	3 - year accreditation	met	—
22-3301 North Shore Children's Salem, MA	50	3 - year accreditation	met	—
22-4013 The Arbour Jamaica Plain, MA	118	3 - year accreditation	not met	L
30-0013 Franklin Regional Franklin, NH	49	3 - year accreditation	met	—
41-4003 Emma Pendleton Bradley Riverside, RI	60	3 - year accreditation	met	—
47-0006 Porter Middlebury, VT	45	3 - year accreditation	met	—
REGION II				
31-0006 St. Mary's Passaic, NJ	251	3 - year accreditation	met	—
31-3026 Kessler Institute/Rehab West Orange, NJ	230	3 - year accreditation	met	—

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
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APPENDIX A

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33-0010 Amsterdam Memorial Amsterdam, NY	73	3 - year accreditation	met	—
33-0080 Lincoln Medical and Mental Health Center MR, Bronx, NY	586	3 - year accreditation	not met	G, Q, M, N, PE-LSC, RC
33-0115 Oneida City Oneida, NY	101	3 - year accreditation	not met	Q, O
33-0394 United Health Services Johnson City, NY	268	3 - year accreditation	not met	Q
33-2016 Coler Memorial New York, NY	270	3 - year accreditation	met	—
33-4027 South Oaks Amityville, NY	265	3 - year accreditation	not met	PE-LSC
REGION III				
09-0006 Providence Hospital Washington, D.C.	382	3 - year accreditation	met	—
09-0009 Capital Hill Washington, D.C.	250	3 - year accreditation	met	—
21-4013 Psychiatric Institute Rockville, MD	88	3 - year accreditation	not met	G, Q, M

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APPENDIX A

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39-0076 Brandywine Caln Township, PA	172	3 - year accreditation	met	—
39-0111 Hosp. of the University Philadelphia, PA	587	3 - year accreditation	not met	PE-LSC
39-0114 Magee Womens Pittsourgh, PA	142	3 - year accreditation	met	—
39-0123 Pottstown Memorial Pottstown, PA	258	3 - year accreditation	met	—
39-0160 Canonsburg Canonsburg, PA	80	3 - year accreditation	met	—
39-0200 Columbia Hospital Columbia, PA	61	3 - year accreditation	met	—
39-4006 Northwestern Institute Fort Washington, PA	146	3 - year accreditation	met	—
39-4008 Friends Hospital Philadelphia, PA	192	3 - year accreditation	met	—
39-4011 Allentown State Allentown, PA	469	3 - year accreditation	not met	Q, PE-LSC, I
39-4033 Montgomery County Norristown, PA	44	3 - year accreditation	met	—

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G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care
R	- Radiologic Services	LSC	- Life Safety Code		

APPENDIX A

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49-0035 Newport News General Newport News, VA	126	3 - year accreditation	met	—
49-0038 Smyth County Marion, VA	133	3 - year accreditation	met	—
49-0067 Southside Regional Petersburg, VA	468	3 - year accreditation	met	—
49-2003 Piedmont Geriatric Burkeville, VA	290	3 - year accreditation	met	—
51-0048 Logan General Logan, WV	123	3 - year accreditation	not met	Q
51-4001 Highland Charleston, WV	80	3 - year accreditation	met	—
REGION IV				
01-0011 Medical Center East Birmingham, AL	282	3 - year accreditation	met	—
01-0062 Wiregrass Hospital Geneva, AL	83	3 - year accreditation	not met	L
10-0012 Lee Memorial Fort Myers, FL	608	3 - year accreditation	met	—

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APPENDIX A

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10-0056 North Beach Fort Lauderdale, FL	153	3 - year accreditation	met	—
10-0067 St. Anthony's St. Petersburg, FL	434	3 - year accreditation	met	—
10-0098 Hendry General Clewiston, FL	66	3 - year accreditation	met	—
10-0142 Jackson Hospital Marianna, FL	107	3 - year accreditation	met	—
10-0167 Plantation General Plantation, FL	264	3 - year accreditation	met	—
10-0194 Humana-So. Broward Hollywood, FL	256	3 - year accreditation	met	—
10-0224 HCA University Tamarac, FL	269	3 - year accreditation	met	—
10-0260 HCA Medical Center Port St. Lucie, FL	150	3 - year accreditation	met	—
10-4024 Circles of Care Melbourne, FL	52	3 - year accreditation	met	—
10-4026 Fort Lauderdale Fort Lauderdale, FL	100	3 - year accreditation	met	—

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APPENDIX A

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11-0092 Dodge County Eastman, GA	117	3 - year accreditation	not met	G, Q, O
11-0196 Henrietta Egleston Atlanta, GA	165	3 - year accreditation	met	—
11-4025 Charter Winds Athens, GA	65	3 - year accreditation	met	—
18-0081 Methodist Evangelical Louisville, KY	372	3 - year accreditation	not met	Q, L
18-3028 Lakeview Rehabilitation Elizabethtown, KY	40	3 - year accreditation	met	—
34-0045 Blowing Rock Blowing Rock, NC	28	3 - year accreditation	not met	L
34-0060 Morehead Memorial Eden, NC	92	3 - year accreditation	met	—
34-0094 Cape Fear Memorial Wilmington, NC	141	3 - year accreditation	met	—
34-0097 Hugh Chatham Memorial Elkin, NC	81	3 - year accreditation	met	—
42-0027 Anderson Memorial Anderson, SC	560	3 - year accreditation	met	—

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APPENDIX A

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42-0039 Wallace Thomson Union, SC	143	3 - year accreditation	not met	L
44-0019 East Tennessee Baptist Knoxville, TN	425	3 - year accreditation	met	—
44-0091 Memorial Hospital Chattanooga, TN	365	3 - year accreditation	met	—
44-0136 Humana-McFarland Lebanon, TN	159	3 - year accreditation	met	—
REGION V				
14-0080 St. Francis Evanston, IL	441	3 - year accreditation	not met	PE-LSC
14-0086 Community Memorial Staunton, IL	59	3 - year accreditation	met	—
14-0103 St. Bernard FD Chicago, IL	252	3 - year accreditation	not met	G, Q, M, N, PE-LSC
14-0192 Lincoln West RS Chicago, IL	201	3 - year accreditation	not met	G, Q, M, MR, PE-LSC, I
14-0210 Harrisburg Med Ctr Harrisburg, IL	77	3 - year accreditation	not met	I, S

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APPENDIX A

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14-4016 Alton Mental Health Ctr Alton, IL	46	3 - year accreditation	met	—
15-0050 Clay County Brazil, IN	96	3 - year accreditation	met	—
15-0089 Ball Memorial Muncie, IN	634	3 - year accreditation	met	—
23-0012 New Center Detroit, MI	122	Unaccredit	met	—
23-0089 Bon Secours Detroit, MI	311	3 - year accreditation	met	—
23-0096 Sturgis Sturgis, MI	67	3 - year accreditation	not met	Q
23-0149 Iron County Iron River, MI	36	3 - year accreditation	met	—
23-0269 William Beaumont Troy, MI	189	3 - year accreditation	met	—
23-4003 Lafayette Clinic Detroit, MI	152	3 - year accreditation	met	—
24-0010 St. Marys Rochester, MN	1158	3 - year accreditation	met	—

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APPENDIX A

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24-0157 Watonwan Memorial Saint James, MN	31	3 - year accreditation	met	—
36-0017 Grant Medical Center Columbus, OH	602	3 - year accreditation	met	—
36-0021 St. Joseph Riverside Warren, OH	248	3 - year accreditation	not met	PE-LSC
36-0024 Providence Sandusky, OH	261	3 - year accreditation	met	—
36-0091 Medina Community Medina, OH	118	3 - year accreditation	not met	PE-LSC
36-0125 Ashtabula General Ashtabula, OH	234	3 - year accreditation	not met	PE-LSC
36-0135 Shelby Memorial Shelby, OH	89	3 - year accreditation	met	L
36-0213 Allen Memorial Oberlin, OH	109	3 - year accreditation	met	—
36-4020 Emerson A. North Cincinnati, OH	80	3 - year accreditation	met	—
52-0038 Hartford Memorial Hartford, WI	71	3 - year accreditation	met	—

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APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
52-0083 St. Mary's Madison, WI	414	3 - year accreditation	not met	PE-LSC
52-0089 Meriter Madison, WI	793	3 - year accreditation	not met	PE-LSC
REGION VI				
04-0080 Harris Newport, AR	120	3 - year accreditation	met	—
04-0088 Med Ctr of So. Arkansas El Dorado, AR	169	3 - year accreditation	met	—
19-0118 Desoto General Mansfield, LA	49	3 - year accreditation	not met	FD
19-0125 St. Frances Cabrini Alexandria, LA	304	3 - year accreditation	met	—
19-0135 Southern Baptist New Orleans, LA	533	3 - year accreditation	met	—
19-0175 Chalmette General Chalmette, LA	114	3 - year accreditation	met	—
19-0189 Riverside Community Bossier City, LA	102	3 - year accreditation	met	—
32-0018 Memorial General Las Cruces, NM	286	3 - year accreditation	met	—

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APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
37-0026 St Marys Enid, OK	263	3 - year accreditation	met	—
37-0065 Craig General Vinita, OK	50	3 - year accreditation	not met	L
37-0113 Grove General Grove, OK	59	3 - year accreditation	met	—
45-0025 Bethania Regional Wichita Falls, TX	235	3 - year accreditation	met	—
45-0055 Rolling Plains Memorial Sweetwater, TX	44	3 - year accreditation	not met	L
45-0115 Gladewater Municipal Gladewater, TX	20	3 - year accreditation	not met	L, RC
45-0193 St. Lukes Episcopal Houston, TX	761	3 - year accreditation	met	—
45-0194 Nan Travis Memorial Jacksonville, TX	106	3 - year accreditation	not met	P
45-0209 Northwest Texas Amarillo, TX	342	3 - year accreditation	not met	P, L, FD
45-0222 Medical Center Conroe, TX	139	3 - year accreditation	met	—

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APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
45-0229 Hendrick Medical Center Abilene, TX	324	3 - year accreditation	met	—
45-0256 Buna Medical Center Buna, TX	33	3 - year accreditation	not met	Q, P, RS
45-0370 Columbus Community Columbus, TX	40	3 - year accreditation	not met	F, G, Q, M, MR, E
45-0399 Brownfield Regional Brownfield, TX	42	3 - year accreditation	not met	L, FD
45-0403 North Texas Medical McKinney, TX	135	3 - year accreditation	met	—
45-0473 Memorial Center, TX	52	3 - year accreditation	met	—
45-0523 Diagnostic Center Houston, TX	167	3 - year accreditation	not met	P
45-0698 Lamb Healthcare Center Littlefield, TX	56	3 - year accreditation	not met	L
45-0719 Mansfield Mansfield, TX	55	3 - year accreditation	met	—
45-3300 Cook Fort Worth Children's Fort Worth, TX	147	3 - year accreditation	met	—
45-4007 Beaumont Neurological Beaumont, TX	120	3 - year accreditation	met	—

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APPENDIX A

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45-4009 Rusk State Rusk, TX	25	3 - year accreditation	met	—
REGION VII				
16-0101 Broadlawns Medical Des Moines, IA	204	3 - year accreditation	met	—
16-0146 St. Lukes Regional Sioux City, IA	338	3 - year accreditation	met	—
17-0022 Atchison Atchison, KS	96	3 - year accreditation	met	—
17-0024 Republic County Belleville, KS	48	3 - year accreditation	met	—
17-0038 Stafford District Stafford, KS	25	3 - year accreditation	met	—
26-0004 Cooper County Memorial Boonville, MO	53	3 - year accreditation	met	—
26-0172 Salem Memorial District Salem, MO	49	3 - year accreditation	met	—
28-0013 Univ. of Nebraska Med Ctr Omaha, NE	352	3 - year accreditation	met	—

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APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
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28-0023 St. Francis Med Ctr Grand Island, NE	175	3 - year accreditation	met	—
REGION VIII				
35-0015 Medcenter One Bismarck, ND	256	3 - year accreditation	met	—
46-4001 Utah State Provo, UT	343	3 - year accreditation	not met	N, PE-LSC
53-0022 Washakie County Memorial Worland, WY	30	3 - year accreditation	not met	Q, O
REGION IX				
03-0051 Gila County General Globe, AZ	149	3 - year accreditation	not met	Q
05-0067 Oak Valley District Oakdale, CA	39	3 - year accreditation	met	—
05-0166 Yolo General Woodland, CA	118	3 - year accreditation	not met	Q, P, PE-LSC
05-0172 Redwood Memorial Fortuna, CA	47	3 - year accreditation	met	—
05-0217 Siskiyou General Yreka, CA	57	3 - year accreditation	met	—

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APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
05-0236 Simi Valley Adventist Simi Valley, CA	145	3 - year accreditation	met	—
05-0258 Rio Hondo Memorial Downey, CA	146	3 - year accreditation	not met	PE-LSC
05-0261 Sierra View District Porterville, CA	93	3 - year accreditation	met	—
05-0280 Mercy Medical Center Redding, CA	206	3 - year accreditation	met	—
05-0300 St. Mary Desert Valley Apple Valley, CA	97	3 - year accreditation	met	—
05-0331 Healdsburg General Healdsburg, CA	49	3 - year accreditation	met	—
05-0348 UC Irvine Medical Center Orange, CA	493	3 - year accreditation	not met	RS
05-0470 Selma District Selma, CA	65	3 - year accreditation	met	—
05-0489 Norwalk Community Norwalk, CA	50	3 - year accreditation	not met	PE-LSC
05-0506 AMI Sierra Vista Regional San Luis Obispo, CA	172	3 - year accreditation	met	—

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APPENDIX A

FY 1989 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
05-0599 UC Davis Medical Center Sacramento, CA	467	3 - year accreditation	not met	PE-LSC
05-0618 Bear Valley Community Big Bear Lake, CA	28	3 - year accreditation	met	—
05-0672 Estelle Doheny Eye Los Angeles, CA	35	3 - year accreditation	met	—
05-4071 Napa State Imola, CA	929	3 - year accreditation	met	—
12-4001 Kahi Mohala Ewa Beach, HI	88	3 - year accreditation	met	—
29-0014 William Bee Ririe East Ely, NV	40	3 - year accreditation	not met	Q, N, RC
REGION X				
13-4004 Aspen Crest Pocatello, ID	62	3 - year accreditation	met	—
38-0055 Bess Kaiser Med Ctr Portland, OR	220	3 - year accreditation	met	—
38-4008 Oregon State Salem, OR	221	3 - year accreditation	met	—
50-0085 Klickitat Valley Goldendale, WA	31	3 - year accreditation	met	—

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M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care
R	- Radiologic Services	LSC	- Life Safety Code		

APPENDIX B

FY 1989 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

		JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION I											
Manchester 07-0027	49	0	4	16	1	21	0	2	24	0	26
Mt. Desert Is. 20-0038	37	0	1	13	0	14	0	0	8	0	8
North Shore 22-3301	57	0	1	11	3	15	0	2	29	12	43
The Arbour 22-4013	50	0	2	19	2	23	1	4	24	4	33
Franklin Reg. 30-0013	35	0	4	12	1	17	0	0	3	2	5
Emma Pendleton 41-4003	38	1	4	17	8	30	0	1	9	14	24
Porter 47-0006	53	0	4	15	0	19	0	2	13	15	30
REGION II											
St. Mary's 31-0006	51	0	5	16	9	30	0	2	3	0	5
Kessler Inst. 31-3026	63	0	3	12	13	28	0	1	6	0	7
Amsterdam 33-0010	47	0	8	21	0	29	0	0	15	3	18
Lincoln 33-0080	61	1	2	25	7	35	7	18	46	10	81
Oneida City 33-0115	57	1	3	13	2	19	2	10	40	0	52
United Health 33-0394	56	0	2	5	0	7	1	12	27	2	42
Coller 33-2016	47	0	1	6	0	7	0	3	5	8	16
South Oaks 33-4027	51	0	1	18	3	22	1	1	5	12	19

APPENDIX B

FY 1989 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS						HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION III											
Providence 09-0006	65	0	6	12	0	18	0	3	15	11	29
Capital Hill 09-0009	592	0	5	20	2	27	0	1	9	0	10
Psychiatric 21-4013	453	0	2	8	0	10	3	5	12	0	20
Brandywine 39-0076	72	0	3	9	1	13	0	0	7	2	9
University 39-0111	56	0	1	7	3	11	1	1	10	29	41
Magee Womens 39-0114	43	1	5	27	0	33	0	0	0	4	4
Pottstown 39-0123	85	0	1	15	4	20	0	0	10	14	24
Canonsburg 39-0160	59	1	1	12	2	16	0	0	6	3	9
Columbia 39-0200	60	1	7	16	0	24	0	0	5	8	13
Northwestern 39-4006	464	1	4	15	2	22	0	0	3	10	13
Friends 39-4008	59	1	3	34	0	38	0	1	9	5	15
Allentown 39-4011	57	1	2	12	4	19	3	7	13	21	44
Montgomery Co. 39-4033	154	1	1	23	9	34	0	0	0	0	0
Newport News 49-0035	57	0	7	24	1	32	0	2	1	6	9
Smyth Co. 49-0038	58	1	5	24	1	31	0	5	11	21	37
Southside 49-0067	52	0	5	15	1	21	0	2	12	5	19
Piedmont 49-2003	49	0	0	5	0	5	0	0	4	0	4

APPENDIX B

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HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Logan 51-0048	347	0	3	17	0	20	1	10	40	10	61
Highland 51-4001	307	0	3	17	0	20	0	4	14	6	24
REGION IV											
Medical Center 01-0011	93	0	6	20	2	28	0	0	5	1	6
Wiregrass 01-0062	43	0	5	49	1	55	1	3	19	5	28
Lee Memorial 10-0012	50	0	3	6	2	11	0	1	1	3	5
North Beach 10-0056	21	0	2	10	0	12	0	0	9	0	9
St. Anthony's 10-0067	56	0	6	19	1	26	0	0	7	0	7
Hendry 10-0098	33	0	7	29	3	39	0	1	6	5	12
Jackson 10-0142	5	0	1	12	0	13	0	0	5	1	6
Plantation 10-0167	43	0	5	14	2	21	0	1	5	6	12
Humana 10-0194	86	0	3	15	0	18	0	2	4	6	12
HCA - Univ. 10-0224	385	0	1	6	0	7	0	0	3	5	8
HCA Med. Ctr. 10-0260	31	0	5	18	0	23	0	0	3	1	4
Circles 10-4024	55	0	6	17	0	23	0	0	0	4	4
Ft. Lauderdale 10-4026	49	0	1	16	2	19	0	1	5	7	13
Dodge Co. 11-0092	47	1	6	30	0	37	3	5	15	8	31
H. Egleston 11-0196	36	0	6	15	0	21	0	0	4	5	9

APPENDIX B

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HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Charter Winds 11-4025	44	1	6	19	0	26	0	1	2	1	4
Methodist 18-0081	7	0	2	7	0	9	2	4	15	22	43
Lakeview 18-3028	349	1	1	6	0	8	0	0	3	0	3
Blowing Rock 34-0045	45	0	2	26	0	28	1	3	23	21	48
Morehead 34-0060	0	0	8	27	2	37	0	1	2	11	14
Cape Fear 34-0094	41	0	3	10	3	16	0	0	1	15	16
Hugh Chatham 34-0097	47	0	7	23	1	31	0	1	4	1	6
Anderson 42-0027	38	0	1	2	1	4	0	0	11	3	14
Wallace Thom. 42-0039	256	0	3	29	2	34	1	6	24	6	37
E. Tennessee 44-0019	38	0	2	6	0	8	0	0	6	0	6
Memorial 44-0091	13	0	2	11	0	13	0	0	3	1	4
Humana 44-0136	33	0	4	13	0	17	0	1	7	4	12
REGION V											
St. Francis 14-0080	776	0	2	6	4	12	1	4	19	15	39
Community 14-0086	21	0	9	23	3	35	0	3	21	9	33
St. Bernard 14-0103	59	0	5	12	7	24	6	11	32	16	65
Lincoln West 14-0192	59	0	6	14	6	26	7	8	22	15	52
Harrisburg 14-0210	51	1	8	24	1	34	2	7	14	14	37

APPENDIX B

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	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS						HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Alton 14-4016	70	0	7	17	2	26	0	1	0	2	3
Clay Co. 15-0050	52	0	7	14	0	21	0	2	35	0	37
Ball 15-0089	41	0	3	9	3	15	0	2	19	8	29
New Center 23-0012	0	7	15	54	0	76	0	3	8	0	11
Bon Secours 23-0089	42	0	5	21	2	28	0	2	14	2	18
Sturgis 23-0096	74	1	4	42	0	47	1	5	17	4	27
Iron Co. 23-0149	93	0	2	17	0	19	0	1	21	4	26
W. Beaumont 23-0269	71	0	1	4	0	5	0	2	5	4	11
Lafayette 23-4003	40	1	3	14	0	18	0	3	4	0	7
St. Marys 24-0010	705	1	6	21	3	31	0	4	10	3	17
Watonwan 24-0157	14	0	8	21	5	34	0	2	20	5	27
Grant 36-0017	57	2	4	14	5	25	0	0	13	5	18
St. Joseph 36-0021	46	0	2	14	0	16	1	1	12	6	20
Providence 36-0024	785	0	1	13	5	19	0	1	11	1	13
Medina 36-0091	47	0	2	24	4	30	1	1	12	11	25
Ashtabula 36-0125	58	0	7	10	2	19	1	3	19	8	31
Shelby 36-0135	623	1	2	26	1	30	1	3	24	2	30
Allen 36-0213	388	0	2	5	0	7	0	0	10	5	15

APPENDIX B

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HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
E. A. North 36-4020	31	0	3	12	0	15	0	0	0	3	3
Hartford 52-0038	49	0	4	17	0	21	0	1	7	10	18
St. Mary's 52-0083	44	0	4	21	2	27	1	2	1	17	21
Meriter 52-0089	62	0	7	11	2	20	1	1	6	27	35
REGION VI											
Harris 04-0080	62	0	2	16	0	18	0	1	1	0	2
Medical Ctr. 04-0088	51	0	4	12	1	17	0	4	2	0	6
Desoto 19-0118	62	0	3	17	0	20	1	4	33	22	60
St. Frances 19-0125	53	0	3	11	3	17	0	2	26	18	46
So. Baptist 19-0125	58	0	4	18	0	22	0	0	3	10	13
Chalmette 19-0175	55	0	2	20	0	22	0	3	10	7	20
Riverside 19-0189	63	0	4	13	0	17	0	1	19	9	29
Memorial 32-0018	36	0	7	12	2	21	0	1	10	6	17
St. Marys 37-0026	72	0	7	15	1	23	0	2	6	5	13
Craig 37-0065	51	0	7	30	2	39	1	0	36	8	45
Grove 37-0113	62	1	12	38	0	51	0	2	17	6	25
Bethania 45-0025	22	0	7	10	3	20	0	4	39	11	54
Rolling Plains 45-0055	68	0	1	17	0	18	1	5	31	5	42

APPENDIX B

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HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Gladewater 45-0115	59	0	4	24	4	32	2	9	51	6	68
St. Lukes 45-0193	58	0	4	10	1	15	0	5	25	11	41
Nan Travis 45-0194	49	0	2	4	0	6	3	9	49	9	70
Northwest TX 45-0209	71	0	2	7	0	9	0	11	28	8	47
Medical Ctr. 45-0222	44	0	3	10	0	13	0	2	20	11	33
Hendrick 45-0229	488	2	4	37	5	48	3	7	33	9	52
Buna 45-0256	58	0	2	15	2	19	6	15	34	13	68
Columbus 45-0370	368	0	1	26	1	28	2	8	60	9	79
Brownfield 45-0399	59	0	2	8	0	10	0	8	33	11	52
North Texas 45-0403	406	0	3	20	0	23	0	7	46	13	66
Memorial 45-0473	42	0	1	6	0	7	1	6	34	7	48
Diagnostic Ctr 45-0523	435	0	3	29	0	32	1	8	25	7	41
Lamb 45-0698	374	0	1	11	0	12	0	8	30	5	43
Mansfield 45-0719	41	0	5	25	2	32	1	16	48	11	76
Cook 45-3300	42	0	3	20	5	28	0	8	39	14	61
Beaumont 45-4007	43	0	3	21	0	24	0	11	38	8	57
Rusk State 45-4009	56	0	2	11	0	13	0	8	42	2	52

APPENDIX B

FY 1989 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS						HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION VII											
Broadlawns 16-0101	54	0	2	10	0	12	0	6	11	9	26
St. Lukes 16-0146	55	0	2	4	0	6	0	7	11	2	20
Atchison 17-0022	75	0	3	18	2	23	0	3	14	2	19
Republic Co. 17-0024	49	0	12	23	0	35	0	4	33	3	40
Stafford 17-0038	29	0	5	22	0	27	0	4	30	6	40
Cooper Co. 26-0004	48	0	5	13	1	19	0	4	18	0	22
Salem 26-0172	404	0	2	15	0	17	0	4	15	0	19
U. of Nebraska 28-0013	58	0	1	10	1	12	0	2	12	4	18
St. Francis 28-0023	37	0	3	22	2	27	0	1	11	13	25
REGION VIII											
Medcenter One 35-0015	30	0	5	18	0	23	0	1	10	12	23
Utah State 46-4001	22	0	5	10	2	17	2	6	9	19	36
Washakie Co. 53-0022	441	0	1	11	0	12	2	5	14	0	21
REGION IX											
Gila Co. 03-0051	56	0	3	22	2	27	1	4	19	10	34
Oak Valley 05-0067	55	0	5	22	0	27	0	1	17	15	33
Yolo General 05-0166	53	0	3	18	4	25	3	15	36	19	73

APPENDIX B

FY 1989 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

		JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Redwoood 05-0172	40	1	3	10	0	14	0	2	22	2	26
Siskiyou 05-0217	799	1	2	12	2	17	0	4	22	7	33
Simi Valley 05-0236	58	0	1	11	4	16	0	5	36	9	50
Rio Hondo 05-0258	57	0	4	16	2	22	1	3	21	14	39
Sierra View 05-0261	405	0	1	15	1	17	0	4	27	16	47
Mercy 05-0280	55	0	5	9	4	18	0	1	17	10	28
St. Mary 05-0300	28	1	4	24	5	34	0	7	37	7	51
Healdsburg 05-0331	40	0	1	10	1	12	0	1	26	15	42
UC Irvine 05-0348	37	1	3	11	2	17	1	4	35	10	50
Selma 05-0470	45	2	5	17	0	24	0	0	7	8	15
Norwalk 05-0489	378	1	9	38	0	48	1	3	23	12	39
AMI Sierra 05-0506	57	0	4	13	2	19	0	3	24	11	48
UC Davis 05-0599	96	0	1	5	3	9	1	3	16	10	30
Bear Valley 05-0618	42	0	3	14	1	18	0	4	20	3	27
E. Doheny 05-0672	59	0	1	3	0	4	0	0	2	4	6
Napa State 05-4071	49	0	1	15	8	24	0	0	16	3	19
Kahi Mohala 12-4001	4	0	0	0	0	0	0	0	1	1	2
W. B. Ririe 29-0014	43	0	4	15	0	19	3	11	53	0	67

APPENDIX B

FY 1989 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS						HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	INTERVAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION X											
Aspen Crest 13-4004	37	0	1	5	0	6	0	0	2	5	7
Bess Kaiser 38-0055	51	0	1	12	5	18	0	1	4	5	10
Oregon State 38-4008	50	0	1	22	0	23	0	1	10	0	11
Klickitat 50-0085	22	0	1	11	1	13	0	2	13	0	15

APPENDIX C

SAMPLE VALIDATION SURVEYS
FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS FY 1988 AND FY 1989

Condition of Participation		FY 1989 (n = 155) Frequency	Percent	FY 1988 (n = 98) Frequency	Percent
Compliance with Federal, State and Local Laws	482.11	1	1	0	0
Governing Body	482.12	6	4	2	2
Quality Assurance	482.21	17	11	9	9
Medical Staff	482.22	5	3	0	0
Nursing Services	482.23	4	3	4	4
Medical Record Services	482.24	3	2	1	1
Pharmaceutical Services	482.25	5	3	1	1
Radiologic Services	482.26	0	0	0	0
Laboratory Services	482.27	12	8	13	13
Food and Dietetic Services	482.28	4	3	3	3
Physical Environment	482.41	17	11	9	9
Infection Control	482.42	3	2	5	5
Surgical Services	482.51	1	1	0	0
Anesthesia Services	482.52	0	0	1	1
Nuclear Medicine Services	482.53	0	0	0	0
Outpatient Services	482.54	3	2	0	0
Emergency Services	482.55	1	1	3	3
Rehabilitation Services	482.56	3	2	0	0
Respiratory Care Services	482.57	3	2	3	3
*Life Safety Code		17	11	13	13

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

APPENDIX D

FY 1989 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
57 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION I					
07-0025 Hartford	861	11/18/88	01/04/89	04/06/89	PE, I
20-0003 Millenocket	50	07/13/89	07/26/89	10/03/89	Q
22-0058 Augusta Mental	86	11/16/88	01/20/89	04/04/89	Q, N, P
22-0060 Jordan	152	11/29/88	12/19/89	02/08/89	E
22-0068 Central	92	12/01/88	01/05/89	06/06/89	Q, G, L
22-0082 St. Johns	254	10/31/88	12/09/88	Pending	N
22-0089 Framingham	290	03/03/89	03/17/89	Pending	Q
22-0100 South Shore	340	07/26/89	08/24/89	Pending	PE, E
22-0101 Newton-Wellesley	335	02/07/89	03/18/89	06/05/89	Q
22-0154 L.F. Quiqley	84	07/06/89	07/27/89	Pending	G, M
22-2200 Youville	305	01/12/89	03/03/89	08/04/89	N
22-4004 MA Mental Health	27	04/10/89	04/29/89	Pending	P, L

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX D

FY 1989 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
57 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION II					
31-4005 Ancora Psychiatric	354	03/03/89	03/27/89	Pending	N
33-0308 Deepdale General	185	05/11/89	08/18/89	01/18/90	Q
33-0397 Interfaith Medical	886	12/29/88	02/17/89	04/20/89	G, Q, N, P MR, FD, PE
REGION III					
21-0002 Univ. of Maryland	785	10/07/88	11/18/88	Pending	Q, M
21-0054 Southern MD	328	01/24/89	03/15/89	Pending	MR
39-0083 JFK Memorial	168	05/08/88		Pending	Q
51-0048 Logan General	123	08/25/89	10/06/89	Pending	Q
REGION IV					
10-0199 Humana/Cypress	273	11/02/88	02/21/89	08/07/89	PE
10-4036 Savannas	70	03/14/89	04/27/89	08/15/89	MR
11-0079 Grady	60	09/28/89	10/20/89	Pending	LS
18-0085 St. Anthony	374	04/07/89	06/02/89	11/13/89	Q, N, MR

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX D

FY 1989 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
57 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
18-0130 Baptist Hosp. East	407	01/24/89	04/26/89	01/22/90	N
25-0113 N. Panola Regional	60	07/11/89	08/22/89	Pending	G, Q, I, L
34-0045 Blowing Rock	28	12/08/88	03/07/89	03/08/89	L
42-0070 Tuomey	235	07/13/89	08/24/89	12/15/89	G, N, I, MR, FD
44-0061 Volunteer General	100	05/18/89	08/29/89	01/22/90	L
44-3303 East TN Children's	119	03/21/89	05/16/89	01/23/90	L
REGION V					
14-0124 Cook County	1018	02/17/89	03/17/89	07/18/89	G, Q, M, N, I, PE, MR
REGION VI					
19-0009 Huey Long Medical	219	02/28/89	03/21/89	08/28/89	N
19-0119 St. Luke General	33	03/08/89	03/21/89	06/06/89	N
45-0031 Charter Surbaran	131	08/24/89	09/19/89	Pending	Q, N, I
45-0057 West Texas	72	02/02/89	04/17/89	10/24/89	RS
45-0064 Arlington Memorial	256	01/12 89	01/31/89	01/09/90	P, A G, RC

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX D

FY 1989 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
57 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
45-0144 Permian	65	03/08/89	03/30/89	09/05/89	P
45-0200 Wadley Regional	448	10/21/88	11/28/88	08/03/89	FD
45-0325 Family	50	06/29/89	07/18/89	Pending	Q
45-0358 Methodist	1327	04/18/89	05/23/89	Pending	N
45-0388 Southwest Texas	475	02/23/89	03/21/89	04/05/89	I
45-0538 Alvin Common	52	08/01/89	08/31/89	12/13/89	Q
45-0539 Central Plains	120	09/07/89	09/25/89	Pending	
45-0558 Humana/Abilene	160	02/10/89	03/06/89	08/24/89	N
45-0647 Humana/Dallas	555	01/13/89	02/15/89	09/28/89	FD
REGION VII					
NONE					
REGION VIII					
06-0028 St. Joseph	565	08/04/89	08/29/89	Pending	P, E

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX D

FY 1989 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
57 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION IX					
03-0025 Wickenberg Comm.	28	04/12/89	05/18/89	11/13/89	PE, LS
05-0049 Linda Vista	150	05/16/89	06/09/89	01/04/90	G, M, N
05-0088 San Luis Obispo	92	04/11/89	05/16/89	Pending	PE
05-0213 Valley Med Center	417	05/24/89	09/12/89	Pending	G, Q, M, MR PE, I
05-0258 Rio Honda Med	146	03/22/89	09/13/89	Pending	LS
05-0265 Yolo General	118	03/07/89	04/06/89	Pending	Q, P
05-0421 American River	250	11/18/88	12/16/88	Pending	M
05-0421 American River	250	06/02/89	09/01/89	Pending	PE
05-0467 Panorama Community	96	02/07/89	06/20/89	Pending	Q, M, E, LS
05-0535 Coastal Community	215	01/13/89	03/30/89	05/31/89	Q, M, E
05-0615 Greater El Monte	250	03/22/89	04/18/89	Pending	G, M, N, S, MR
05-0669 Valley	18	11/16/88	12/20/88	01/30/89	G, M, Q
REGION X					
NONE					

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX E

ALLEGATION INVESTIGATION SURVEYS COMPLIANCE AND NONCOMPLIANCE DECISIONS

ALLEGATION INVESTIGATION SURVEY DECISIONS	FY 1988 NUMBER	FY 1988 PERCENT	FY 1989 NUMBER	FY 1989 PERCENT
Hospitals in compliance	203	86	525	90
Hospitals out of compliance	32	14	57	10
Surveys performed	235	100	582	100
REASONS FOR NONCOMPLIANCE	**NUMBER**	**PERCENT**	**NUMBER**	**PERCENT**
Hospitals out of compliance with Life Safety Code only	1	3	3	5
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	2	6	1	2
Hospitals out of compliance for reasons other than Life Safety Code	29	91	53	93
TOTAL	32	100	57	100

APPENDIX F

ALLEGATION INVESTIGATIONS
FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS
PLACED UNDER STATE AGENCY SURVEILLANCE
FY 1989 (n = 57)

CONDITION OF PARTICIPATION	NUMBER	PERCENT
Compliance with Federal, State and Local Laws. 482.11	1	2
Governing Body 482.12	11	19
Quality Assurance. 482.21	21	37
Medical Staff 482.22	10	18
Nursing Services 482.23	16	28
Medical Record Services. 482.24	8	14
Pharmaceutical Services....482.25	8	14
Radiologic Services 482.26	0	0
Laboratory Services 482.27	6	11
Food and Dietetic Services 482.28	4	7
Physical Environment. 482.41	9	16
Infection Control. 482.42	7	12
Surgical Services 482.51	1	2
Anesthesia Services 482.52	1	2
Nuclear Medicine Services 482.53	0	0
Outpatient Services 482.54	0	0
Emergency Services. 482.55	5	9
Rehabilitation Services. 482.56	1	2
Respiratory Care Services 482.57	1	2
Life Safety Code	4	7

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

APPENDIX G

SAMPLE VALIDATION SURVEYS - VALIDATION DECISIONS BY SURVEY PERIOD

ALLEGATION INVESTIGATION SURVEY DECISIONS	FY 1988		FY 1989		ALL PREVIOUS REPORT PERIODS (INCLUDING FY 1988)	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	66	67.4	110	71.0	510	47.0
Hospitals out of compliance	32	32.6	45	29.0	576	53.0
Surveys performed	98	100.0	155	100.0	1086	100.0
REASONS FOR NONCOMPLIANCE	**NUMBER**	**PERCENT**	**NUMBER**	**PERCENT**	**NUMBER**	**PERCENT**
Hospitals out of compliance with Life Safety Code only	4	12.5	0	0.0	302	52.5
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	9	28.1	17	37.8	165	28.6
Hospitals out of compliance for reasons other than Life Safety Code	19	59.4	28	62.2	109	18.9
TOTAL	32	100	45	100	576	100

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